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S. Hrg. 103-216, Pt. 1

HEALTH SECURITY ACT OF 1993

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PT.1
Health Security Act of 1993, S.Hrg....

HEARINGS

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

ON

EXAMINING THE ADMINISTRATION'S PROPOSED HEALTH SECURITY ACT, TO ESTABLISH COMPREHENSIVE HEALTH CARE FOR EVERY AMERICAN

SEPTEMBER 29, 30, and OCTOBER 5, 6, 15, 19, 1993

PART 1

Printed for the use of the Committee on Labor and Human Resources



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HEALTH SECURITY ACT OF 1993

WEDNESDAY, SEPTEMBER 29, 1993

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10:04 a.m., in room SR–385, Russell Senate Office Building, Senator Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Mikulski, Bingaman, Wellstone, Wofford, Kassebaum, Jeffords, Coats, Gregg, Thurmond, Hatch, and Durenberger.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. We will come to order. We are now beginning the most significant domestic policy debate since Medicare was enacted almost 30 years ago, and it is appropriate that as the Senate begins its action on this issue, we are meeting in this caucus room that has witnessed so many historic hearings going back to the earliest years of this century.

Congress enacted Medicare in 1965 because the Nation had reached a consensus that action was essential to end the health care crisis affecting senior citizens. Today, a comparable crisis faces every American family and action is just as urgent.

The key to success in this undertaking is bipartisanship. Going back over many years, no major reform has been enacted without bipartisan support. This committee has had a tradition of bipartisanship, a tradition which I am confident will be extended to consideration of the Health Security Act. All of us intend to work closely together and with the administration. The final bill that Congress approves needs and deserves the support of both Democrats and Republicans, and the country expects that kind of participation and consideration.

No individual has contributed more to the development of the President's plan than our witness this morning, the First Lady, Hillary Rodham Clinton, and she has worked tirelessly with great skill to shape this plan. In doing so, she has reached out to a large number of citizens, to experts on all sides of the debate, and to all of us in Congress. Her leadership has been extraordinary, and we are honored by her presence here this morning.

I am looking forward to working with all the members of this committee, the Finance Committee, and the other committees in the Senate with jurisdiction over the many complex aspects of our health care system. Today, Mrs. Clinton testifies here before the

Labor and Human Resources Committee. Tomorrow, she will testify before the Finance Committee.

I know that under the guidance of Majority Leader George Mitchell and Republican Leader Bob Dole, we will work as closely as possible together to pass a bipartisan bill that meets the goals the President has set and that the American people deserve.

Senator Kassebaum.

OPENING STATEMENT OF SENATOR KASSEBAUM

Senator KASSEBAUM. Mr. Chairman, I certainly agree with you that Mrs. Clinton has provided extraordinary leadership. It is a pleasure to welcome you here this morning, at our first formal hearing.

The task before us is numbing in its complexity. It is also rich in opportunities for political conflict. For some of us, the challenge will be to make sure our concerns about the specifics of reform do not overwhelm the commitment to making it happen. For others, the challenge will be the reverse to temper eagerness to move a bill with recognition that lasting reform cannot occur without careful deliberation and sincere compromise. Obviously we cannot achieve this overnight, but I have great confidence that bipartisan compromise will ultimately be achieved.

I would like to ask that my full statement be made a part of the record, Mr. Chairman.

The CHAIRMAN. Fine. Thank you very much.

[The prepared statement of Senator Kassebaum follows:]

PREPARED STATEMENT OF SENATOR KASSEBAUM

I am pleased to welcome the First Lady before our committee as we begin the long and difficult process of debating national health care reform.

The task before us is both numbing in complexity and rich in opportunities for political conflict. Health reform could well be the greatest challenge that either this committee or Congress faces in this decade—and how well we respond will be nothing less than a test of our capacity to govern.

For some of us, the challenge will be to make sure our concerns about the specifics of reform do not overwhelm our commitment to making it happen. For others, the challenge will be the reverse—to temper eagerness for moving a bill with recognition that lasting reform cannot occur without careful deliberation and sincere compromise.

Consensus cannot be achieved overnight, but I am optimistic that bipartisan agreement will ultimately be reached on this issue. I am encouraged for example, that elements of my own bipartisan BasiCare health reform bill have been incorporated into both the President's plan and into the new Senate Republican proposal.

Nearly all of us of both parties sincerely share the basic goals eloquently outlined by the President last week: security, savings, simplicity, quality, choice, and responsibility. Bipartisan common ground is also growing on a wide range of important details in this debate, ranging from protections for persons with pre-existing

health conditions to the need for standardization of medical paperwork.

Our job now is to roll up our sleeves and get to work on the tough issues over which we differ.

For me, a major concern is the administration's proposal to create massive new regional insurance monopolies to manage and regulate nearly all aspects of health care in the United States. Most Americans probably don't yet realize what these so-called "health alliances" will mean for them—but when they do, I doubt they will like what they see.

Under this new system, nearly all Americans would be mandated to buy insurance through exclusive regional alliances set up by the States. Accountable to virtually no one but government, the alliances would have broad regulatory authority to decide which health plans consumers can choose and what these plans will look like—as well as to dictate monopoly rules to health plans, doctors, and hospitals.

In my view, powerful and regulatory alliances insert an unneeded, bureaucratic, and authoritarian level of control into a system already clogged with rules and paperwork. The last thing we need is a new layer of middlemen processing our health care dollars.

If the President wants simplicity, this is not the way to achieve it. A better alternative would be to build reform around small and voluntary purchasing cooperatives. Combined with a uniform benefit package, community rating premiums, and risk-adjustment among health plans, voluntary cooperatives could give small purchasers the market clout they need, but without requiring costly and cumbersome apparatus of massive alliances.

The huge cost and questionable financing of the White House proposal is another area where I have serious questions. Can we trust the numbers? Are we putting promises ahead of payment? Is cutting Medicare and Medicaid to pay for new entitlements just another way of robbing Peter to pay Paul?

Can we ever end cost-shifting if we do not integrate Medicare into the new system? Moreover, can we justify creating a new entitlement for early retirees when our existing entitlements are bursting at the seams? And most important, can the American taxpayer really afford the cost of guaranteeing a Fortune-500 plan to everyone?

Like many, I am also concerned about the administration's proposal to mandate that every employer pay 80 percent of the cost of providing insurance to its employees. Even factoring for the subsidies the President proposes, the impact of the mandate on small business through reduced wages and lost jobs could be great.

In Kansas 74 percent of businesses have fewer than 9 employees. Many of these small firms have very narrow profit margins, which means that even a capped mandate of only 3.5 percent of payroll could mean the difference between breaking even and going under. A further drawback to the administration's mandate proposal is the complex tangle of subsidies it would establish.

Finally, on the issue of cost containment, I am pleased that the administration has adopted a version of my own proposal to limit the rate of growth in insurance premiums. I believe this basic ap-

proach offers a way to firmly restrain costs, but with a relative minimum of bureaucratic micromanagement. I am extremely troubled, however, by the rapid and heavy- handed way such premium limits would be implemented under the White House plan. Forcing premiums down to CPI over just 2 years is realistic—and if enacted, such severe reductions could do serious harm to our health care system.

These and other questions will take time to work through, but I am to eager for the challenge and look forward to beginning the process here today.

The CHAIRMAN. Mrs. Clinton, we would be glad to hear from you.

We will have a 5-minute time limitation for the members. Thank you very much.

STATEMENT OF HILLARY RODHAM CLINTON

Mrs. CLINTON. Thank you, Mr. Chairman. Thank you, Senator Kassebaum. I want to begin by thanking the members of this committee for the consultation and advice that you have given me over the last months. I have met not only with this committee several times, but with many of the members individually numerous times, and I am very grateful for the assistance that you have given me.

It is an historic opportunity as we come together in this Senate caucus room. This is a place where much of America's history has been played out. It is a place where, years ago, President Kennedy announced his campaign for the Presidency. Eight years later, Senator Robert Kennedy announced his own Presidential candidacy here.

Your family, Mr. Chairman, and your commitment to health care reform bears special notice. It is a commitment that goes back 25 years, and you have added your own stamp to our history in this room and your name has been attached to every piece of health legislation that has passed through Congress. So I am especially grateful that we would have this opportunity to begin this discussion about the future of health care reform before this committee in this room.

I am also grateful because this committee has shown a welcome and courageous spirit of bipartisanship when addressing difficult social problems. For the good of the Nation of many occasions, you have put aside partisan and ideological differences. That tradition of open-mindedness and courage will be beneficial to all of us as we work toward lasting, substantive health care reform in the months ahead.

Like you, I have had the opportunity to travel around the country and listen to thousands and thousands of ordinary Americans talk about health care. I have listened to the employed, the self-employed, the unemployed, those who labor in our factories, on our farms, in our offices, those who never have had to worry about health care because of their financial affluence.

I have read letters from, I think, every State represented here that came in amongst the more than 700,000 pieces of mail received at the White House from citizens pouring their hearts out, sharing their stories, and offering their suggestions. Nothing is more important to our Nation than ensuring that every American

has comprehensive health care benefits that can never be taken away.

When the President laid out his goals for health care reform, he was committed to building on what is right in our current system and fixing what is wrong. That principle will guide us throughout this debate. We want to preserve and strengthen the high quality of medical care that is a trademark of our Nation—our unrivaled doctors, nurses, hospitals, and sophisticated technology. We also want to honor every family's desire to choose a doctor and other health care providers.

At the same time, we have to be equally committed to fixing what is clearly broken. Each month, more than two million people lose their health insurance for some period of time. Every day, thousands discover that, despite years of working hard and providing for their families, they are no longer covered. Every hour hundreds who need care wind up in our emergency rooms because they have no health care insurance.

These are not isolated and individual tragedies because every person who loses health benefits, who is denied health insurance, is part of a growing national problem. This is a problem that is not only causing human tragedies, but undermining our social fabric, reducing our Nation's productivity, draining our Federal and State budgets, as well as denying hard-working Americans the kind of wage increases that they deserve to have because their compensation is so heavily weighted now toward health benefits instead of wages.

You have, as I have, heard the stories about those insurers, 40 percent of whom refuse coverage to people with so-called preexisting conditions. Up to 30 percent of employees report they are afraid to switch jobs for fear they will lose their health insurance, and hundreds of thousands of people are locked into our unproductive welfare system because to leave welfare would mean giving up Medicaid benefits. The harmful effects of the rising health care costs on our work force and on our Nation cannot be overestimated.

I think all of us as we move through this debate have to put ourselves into the lives and into the terrible stories that we all know as well: to really know what it feels like to be the most qualified applicant for a job but be told you can't be hired because your child has an illness that will drive up the company's health care premiums; to be told that if you leave the job you have to take a better opportunity, which is the American dream, to move to another city and move up the ladder of success, you will lose your health care coverage. Imagine the disillusionment of those people who have worked so hard all their lives who now, because of economic changes, lose that job, are laid off, and find themselves without health care coverage.

Today, the average worker pays $7,423 for health care each year. If we don't change our system now, that amount will rise to $12,386 by the year 2000, and as the average worker's bill for health care goes up, his or her real wages will decrease by about $655 a year by the end of the decade. Today, the trade we are offering American workers is to give up any wage increases that they deserve and that they have earned in return for less health care coverage and less health security.

When I was with you in Massachusetts last spring, Mr. Chairman, we met a number of small business owners and had a conversation with them. One man particularly stays in my mind. He owned a small family bowling alley. He also manufactured great ice cream, homemade, right there at the alley. He had one longtime employee. That is the only person he employed, and that man's son became seriously ill. As a result of the boy's illness, the cost of that very small business' health insurance premiums went up.

As I am sure you remember, Mr. Chairman, that bowling alley owner told us with tears in his eyes how confounded and confused he was by being left with the choice of either firing his longtime employee, denying the man coverage for his family when he needed it most, or continuing to pay the rising cost of health premiums, knowing that that increasing cost could undermine the success of his family business.

In our current system, stories like these have become too common. That is why we must finally ensure that every American citizen has comprehensive health benefits that can never be taken away, not when you lose a job, not when you change jobs, not when you move, and not when someone in your family gets sick.

We have learned probably more about the technicalities and details of health care and the way it is delivered in this country in the last months than any of us ever knew before. But what I know most and what I care about most is what I have learned from personal experiences. Because when you strip all the technical details away, what health care really matters is what is there for you when you need it.

Those of us who are well-insured, those of us who do not have to worry about getting the best care that can be offered anywhere in the world, I hope will always keep in mind the mothers and the fathers and the sisters and the brothers and the children of this country who do not share that sense of security.

We want to emphasize primary and preventive health care as well because we think that will save us money and provide more security for all Americans. We want to extend prescription drug benefits to all Americans, but particularly older Americans, because we have heard more about the costs of prescription drug increases than probably any other issue from older Americans.

We want to be sure that we begin to provide long-term care for older Americans. The choices we now pose to families are just unconscionable in many instances—spend yourself into poverty in order to find a safe, secure nursing home for your family. You can't get care for taking care of that family member in your home. You can't get reimbursed for a much cheaper form of care in your community. All that is available is a nursing home.

We also want to be sure that everyone's health care needs are taken care of, and I want to say a particular word about women's health care needs. For too long, women have been relegated to the fringes of medical research and medical care. The leading cause of death among women in our country is coronary disease, but until recently women were routinely excluded from major coronary clinical trials, and I want to thank this committee for its leadership in including women where they rightfully belong, at the forefront of being taken care of in our health care system.

But we still have a ways to go. We need to focus on other diseases such as osteoporosis. We need to provide diagnostic tests like mammography and pap smears. We need to be sure that women, who are the primary caretakers of our families, are taken care of.

By ensuring comprehensive benefits to all Americans, by emphasizing primary and preventive health care that saves money and keeps people healthy, and by devoting more attention to the special health problems of women, we can control costs and build a healthier Nation and make our economy and our work force more productive.

I want to thank the members of this committee for the assistance you have already given to us, and thank you ahead of time for what I know will be a very productive and fruitful relationship as we move forward to solve this problem.

The CHAIRMAN. Thank you very much, Mrs. Clinton. I think as we examine the proposal, there is obviously a long list of detailed questions that come to mind, a number of which we will examine today. But I think it is important that we don't lose sight of the real importance of this program and how it will affect families all over the country.

I was wondering if you could really elaborate for just a moment about what this program will mean to most American families. I don't like to use the word "average" because no one is average, but how would you describe for most working families what this program really means to them, for their situation today and for their future?

Mrs. CLINTON. Mr. Chairman, I think that is exactly the right question to ask because we have to look at what we want to do to try to increase security for Americans, and particularly American families. I would describe the impact on most families in terms of security, and break it down into several different kinds of security.

I would start by the obvious that we will be able to look every American in the eye and say that they are guaranteed health security. The health security card that the President held up during his speech is a symbol of what we mean when we will be able to say that. Every American who is entitled to that card will have one, and standing behind it will be a guaranteed set of benefits.

I think we will also be able to tell American families that they will be more economically secure. Right now, what has happened over the past decades is that most American families have seen their standard of living either stagnate or begin to diminish because wage increases have not been able to keep up with inflation at the rate that they did in the decades previous to the 1970's and 1980's.

Many American families feel immense economic insecurity, and what they may not realize is how our rising health care costs—the burdens that have been imposed on both government, and particularly business, is directly related to the kind of economic insecurity that too many Americans feel. We believe that we will be able to stabilize the amount of money that we will spend on health care, and because of that we will be able to bring costs down for many businesses. As a result, we hope we will begin to see wages react accordingly and economic security once again become a cornerstone of American working life.

I guess I would finally say, Mr. Chairman, that I think we will provide a lot of psychological security. One of the issues that worries me a great deal is how alienated and how insecure many of our people seem to be. Clearly, in material ways, they are not less well off than my parents and grandparents were during the Depression, but in psychological terms they feel that the future is closing in on them, that they aren't taken care of, that they can't count on their children having the same kind of opportunities as they did.

I don't think there is anything more important to establish than the fact that they will not have to worry about health problems that come up and that might undermine their sense of security. So in those very important respects, I think we will find through health care reform not only what we will be taking about in terms of benefits and cost containment and the like, but we will find a shift in attitude among our people that will render them more secure. I therefore believe our citizens will be more productive, and more willing to face the future with the kind of confidence that we need in America.

The CHAIRMAN. Well, that is a certainly an enormously important change in attitude among the American people going back to kind of a community of caring, which I think is a central challenge of this society. As the President has pointed out in his speech, you can also be for this program because it gets a handle on the Federal deficit. You can be for it because it reduces bureaucracy for the providers. You can be concerned about the increasing share of profits that are taken away from American businesses.

But I think for many who want this program enacted, it is because of their out-of-pocket costs to doctors and to hospitals, are rising beyond their ability to pay and I think many people will want to know whether this program is really going to do something about these costs. This is of enormous concern to most Americans, those that have health insurance as well as those that don't. What kind of impact do you think that this program will have on those working Americans and others who have seen the extraordinary increase in out-of-pocket costs?

Mrs. CLINTON. Our estimate is, Mr. Chairman, that for Americans who are currently insured, about 63 percent will have the same or better benefits at less cost or the same cost, and that includes out-of-pockets, it includes deductibles. Individual consumers will be able to make choices that will drive those costs down even lower because we will, we believe, through this reform enhance the number of choices available to citizens. If they want to choose an organized network of doctors or a health maintenance organization that has very low or no co-pays, they will be able to do that.

Another issue that is very important to many families is that we want to eliminate the lifetime limit kinds of considerations that in too many insurance policies have required people, once they have exhausted their limits, to pay out of their own pockets. We think that if you are insured, you should be insured across the board.

We also believe that we should bring down the cost of deductibles. Deductibles will still be present, but will be set at manageable level. So if we take into account all of these costs, we will have, we believe, a significant decrease in out-of-pocket ex-

penditures both for the premium share as well as co-pays and deductibles for many people who are currently insured. For about 20 to 22 percent of those who are insured, they will pay a little bit more, but they will be getting more comprehensive benefits because they are now paying too much for catastrophic or major medical policies, often with a very, very large deductibles. Those deductibles will be dropped. Their benefits will increase. So, over a lifetime, they will also realize cost savings, even though initially they may pay a little more.

For about 12 percent of the people, they will pay more for about the same benefits. Those are largely young, single people who now benefit from an insurance system that is really skewed in their direction because those of us who are older, and anyone who has ever been sick, pays much more than they should, while young and single people pay less than they should in terms of being part of an entire community pool. So they will pay a little more in these early years, but they too will realize benefits over their lifetime.

The CHAIRMAN. Thank you.

Senator Kassebaum.

Senator KASSEBAUM. Mrs. Clinton, as you know, I have been concerned about the health alliance structure and have worried about the size, the monopolistic purchasing power, and the sweeping regulatory authority of such alliances. I would like to ask you some questions to clear up just how these entities would work.

In Kansas there are only 6 employers who have 5,000 or more employees. Now, it is my understanding that 5,000 employees is the cut-off and that everyone below that must be enrolled in and buy insurance through the alliance.

Mrs. CLINTON. Senator, it is 5,000 nationwide. So if there are employers in Kansas who are part of larger companies, even though their employment levels in Kansas may be less than 5,000, if the aggregate nationwide is 5,000 or above, they can be part of a self-insured alliance.

Senator KASSEBAUM. Do all insurance dollars both from employers and employees—go into the alliance?

Mrs. CLINTON. Yes, for the guaranteed benefits package. Now, there will be, we anticipate, not only supplemental insurance, but new insurance markets for products like long-term care and those will go directly to insurers, or if an alliance wants to contract with an insurer in order to handle those dollars, it could be done that way. But there will still be an insurance market outside of the alliance.

Senator KASSEBAUM. What type of care would require additional markets?

Mrs. CLINTON. For anything that is outside the guaranteed benefits package, so that, for example, if a person wanted more mental health benefits or long-term nursing home care, the alliance would be able to offer those through health plans. In addition, there will also be an independent insurance market as well for benefits that people want to buy with their own dollars in addition to the premium dollars.

Senator KASSEBAUM. Well, for instance, if you are with Blue Cross/Blue Shield and that had been your longtime carrier, but they did not opt to go into the alliance or the alliance didn't include

them as part of the insurers participating, do you have any choice at that point of where you go?

Mrs. CLINTON. Well, Senator, we anticipate that Blue Cross and other insurers will be in the business of running and offering the accountable health plans. It is almost inconceivable to envision that Blue Cross/Blue Shield would not opt to offer a plan—or be ineligible to do so—within a regional alliance.

In our conversations with a number of insurance companies, what they are moving toward is what they are already doing, which is to help organize networks of physicians and hospitals into the delivery points. So they would, in effect, become the managers of the accountable health plans.

So if you had Blue Cross/Blue Shield now and the Blue Cross/Blue Shield health plan were one of your choices, much as we now have with the Federal employees plan, you might very well continue to be insured by Blue Cross/Blue Shield.

In the future, in the alliances, it will be just the same kind of model as is the case in the Federal Government. The money will go into the alliance, as it does now with the Federal Government, but the choices available will be perhaps the local HMO, the Blue Cross/Blue Shield health plan. Maybe the local hospitals have created, you know, the Lawrence, KS, plan or whatever it might be. So there will not only continue to be a role for insurance companies in managing and delivering care, but we anticipate that it may even be an expanded role in that area.

Senator KASSEBAUM. Could you go outside the alliance for the purchase of your insurance?

Mrs. CLINTON. Let me walk through this. If you are an employee now or an employer, you make your premium payments directly to the insurer, and the insurer then decides in some instances which doctors or hospitals you can attend, or you have a fee-for-service plan and then you pick and the insurance company reimburses your doctor.

In what we are proposing, the alliance is the body to which the money is paid. The accountable health plans are what you now think of as your health plan, whether it is Blue Cross/Blue Shield, some health maintenance organization, or some other form of health plan. The money goes into the alliance so it can be pooled there. We propose doing it this way because we want to get the most purchasing power possible—just the way it happens now with the Federal Government, in Minnesota like some of the very large purchasers of care there, or in California like the CALPERS system. They are formed to pool purchasing power. Then the health plans like Blue Cross and the others come and say, we can deliver the guaranteed benefits package at this price.

Then each year, every consumer, as you do now with the Federal plan, will get a brochure about all of the plans. The alliance is merely a collection agency. Every plan that is qualified has the right to bid for your money and you then tell the alliance, send my money to Blue Cross, and that is how you get your health care.

Senator KASSEBAUM. I just got a note that I have 2 minutes remaining, so I will be brief. The alliance is appointed by the governor or the legislature of a State, is that correct?

Mrs. CLINTON. Well, the governors think that it ought to be the governors. The legislators think they ought to have a role.

Senator KASSEBAUM. But the fact is, they have a great deal of authority in setting out some very firm guidelines for the alliances. And then there are the guidelines of the national board, which supersede, do they not, some of the directions the alliances receive from the States.?

Mrs. CLINTON. What we would like is to have Federal guidelines. For example, what is a qualified health plan and what is the benefits package? Then each alliance would implement those Federal guidelines. But we also want to give some flexibility to alliances because we know that western Kansas is not the same as Kansas City. So we want some flexibility so that an alliance could have some opportunity to maybe do things a little bit differently in one part of the State from the other, but they would all have to meet the basic Federal guidelines of what the health plans would have to be.

Senator KASSEBAUM. Thank you.

The CHAIRMAN. Senator Pell.

Senator PELL. Thank you, Mr. Chairman, and I congratulate you in choosing this room, where so many historic events have occurred, for this hearing on a subject and a program whose time has come. We are seizing it, and I hope under the leadership of Mrs. Clinton we will move ahead with it.

I think the affection and regard of the country for you was shown at the joint session speech when the applause was louder than I have heard for anybody who was not the principal speaker himself in the 33 years I have been in the Senate. The affection and regard is universal, I think.

The question specifically that I have in mind concerns unemployment. This little chart—your eyes may be better than mine and you can see—shows that the unemployment in my State of Rhode Island is far worse than it is on average in the country as a whole. Who would pay the premiums on this health plan when one is unemployed? Would it be the employer? There is no employer. Would it be the public, or who?

Mrs. CLINTON. It would be the public through the Federal Government. The Federal Government will provide the insurance share for the unemployed, and when someone is employed there will be a combination of contributions from the employer and employee. In some cases, such as for small businesses who have low wage employees, will underwrite discounts for the health premium contribution.

Senator PELL. In that regard, how does this little health security card work that I have seen? It was presented to me. It has got somebody else's name on it, I regret to say, but how does it work, in fact? Is it like a charge card or credit card?

Mrs. CLINTON. That is the way we would like to see it work because one of the ways we think we can save billions of dollars in this system is to move toward electronic billing, to move toward single forms to try to simplify the collection of the health care dollars. So, yes, we would like to see the health security card working very much like a credit card in which we will have much more

economies of scale in terms of collecting and paying out money throughout the system.

Senator PELL. Thank you. The columnist, Ann Landers, wrote a column which, without objection, I would like to see inserted in the record.

The CHAIRMAN. It will be inserted.

[The column referred to follows:]

THE WASHINGTON POST—SEPTEMBER 19, 1993

(By Ann Landers)

Dear Ann Landers: What is happening to our beloved country? Every time I pick up a newspaper, I read yet another horrible story about a child killed by gunfire.

In Chicago, 7-year-old Dantrell Davis was shot in the head and killed as he was entering his school. The following week, three teenagers were wounded outside their high school in the Bronx. A few days later, three more teenagers were shot near their high school in Brooklyn.

I have three children under 12. Since they were tots, I have instructed them to be careful when crossing the street, but it seems they are in greater danger of being hit by a bullet than by a car.

What is going on that puts ordinary, everyday people at risk of being shot? Please explain this because I am utterly—Baffled in Brooklyn.

Dear Brooklyn: I'm glad you asked because you've provided me with an excellent opportunity to present some alarming statistics.

The United States is the most heavily armed Nation on earth. Its 255 million people possess more than 200 million guns—73 million rifles, 66 million handguns and 62 million shotguns.

In 1990, 2,874 boys and girls 19 years of age and younger were murdered with guns. According to Lou Harris pollsters, four out of 10 teenagers said they knew someone who had been shot.

About half of all handgun owners keep their guns loaded at all times. Whenever you read about a 5-year-old or 6-year-old who shot a playmate or himself, you become painfully aware that the child somehow managed to get his hands on a loaded weapon.

In spite of all the terrible things guns are doing to our lives, Congress still hasn't passed the Brady bill. This bill asks only for a waiting period of five working days so a background check can be made on gun purchasers.

American women have been taught to fear violent crime by strangers. The gun industry is using this fear to sell guns to women under the guise that guns will protect them. This is false. According the New England Journal of Medicine, a handgun in the home is 43 times more likely to be used to kill the owner, a family member or a friend than to kill an intruder.

The National Rifle Association is the most powerful special interest group in the country. The extremists who control the NRA spend more than $100 million a year to defeat every gun law proposed. The NRA has lobbied shamelessly against banning machine guns, plastic pistols and cop-killer bullets designed to pierce bullet-proof vests.

America is the most violent Nation in the world. To give you some notion of just how violent it is, here are some comparisons: In 1990, handguns murdered 10 people in Australia, 22 in Great Britain, 68 in Canada and 10,567 in the United States. The easy availability of handguns is at the root of this problem. The NRA says, "Guns don't kill people, people kill people." Of course they do. But they use guns to do it.

Senator PELL. It points out the number of deaths from guns. As you may know, the annual cost of hospital care associated with firearms treatment is about $1 billion. In Rhode Island alone, the estimated annual health care costs attributable to those killed by firearms between 1984 and 1990 was about $22 million.

What would be your reaction to the thought of introducing legislation that would have a tax on firearms with that tax devoted to the health plan?

Mrs. CLINTON. Well, Senator, that is not part of the President's proposal, but I think that there is interest in that proposal. I was

asked the same question yesterday in the House, and targeting some kind of payment for violent crime to our health care system might be something worth considering.

Senator PELL. Another question is on research in hospitals. We have in my State some very fine teaching hospitals, and I am curious how the President's health plan will impact on their quality. As you know, when you have a research institution, it increases the quality of care. It also increases the expense.

Mrs. CLINTON. That is a very important question and one that we have talked a lot with the deans of our various medical schools around the country about. We believe that the academic health centers ought to be the quality foundation for this health care plan. Rather than reinventing the wheel and creating any new kind of bureaucracy or entity to keep track of quality and to try to determine outcomes related to procedures, we would like to see that research and that kind of quality reporting function really housed in our medical schools around the country. We think they are fully capable of doing that work.

We also know that many medical schools and academic health centers have higher costs because the care that they deliver is so highly specialized. So we have some special provisions to help support financially those academic health centers so that they are available to patients not only in the States where they are, but also around the country if they have developed a certain technique or procedure that should be used because of its importance. In short, we take very seriously the role of the academic health centers, and have some provisions that we think will strengthen their position in the health care system.

Senator PELL. Thank you very much.

Mrs. CLINTON. Thank you, Senator.

The CHAIRMAN. Senator Jeffords.

Senator JEFFORDS. Thank you, Mr. Chairman. First, I want to commend Senator Kassebaum for all of her help and leadership on our side of the aisle, and I want to commend you, Mr. Chairman, for your efforts leading up to this important occasion. I know that you are delighted, as I am, that the process is now underway to finally make health reform a reality.

I also want to commend you, Mrs. Clinton, for your efforts, particularly for your and your staff's willingness to work with all of us, my party especially. I know it was helpful for us and I hope it was helpful for you.

I am sure managing your task force of 500 was a tough job, but I suspect it was nothing compared to the task force of 535 that are here on Capitol Hill that you now have to deal with. Thus, the toughest part certainly remains before us.

The principles that guide your effort and most of the major policy choices you have made mirror my own. You have made a great start, but a vast amount of work still needs to be done. I hope we can improve upon your proposal, particularly with regard to financing, bringing costs down, and promoting good health. To do so, I am convinced, will require the talents and energy of Republicans as well as Democrats. No party has a monopoly on wisdom or experience. You, in your role as the first navigator, know better than most that we are sailing into largely uncharted waters.

I think it is critical to the country that this be a bipartisan effort. I know of no better way to ensure it than to join as a cosponsor of your legislation upon its introduction. I will do so, but I want to do more than this. I want this bill to be broadly bipartisan, and I pledge to do what I can to make this a bill Republican colleagues can support.

I have been thinking about our Nation's health care problems for many years and have definite ideas on what our health care goals ought to be and how they can be accomplished. I don't think anyone would disagree with the administration's goals. Everyone in this Nation needs the security of knowing that no matter whatever else happens in their life, they can count on the fact that they have good, quality health care. We need a much simpler health care system with far less paperwork. Finally, we need to be sure that our new system will get health care costs under control.

I look forward to working with you and the administration and my colleagues on both sides of the aisle in this essential effort. I agree with the administration's approach and will do what I can to ensure that the historic proposal becomes law next year.

Now, a question.

Mrs. CLINTON. May I just say thank you very much, Senator Jeffords. I know that you share the President's and my belief that this is an issue beyond partisan politics, and I think most of the members of this body share that same belief. We will look forward to working with you and other Republicans. We have learned a great deal from you and the work that you had done. I read your bill, I read Senator Kassebaum's bill. We learned a lot about the appropriate way to address our health care needs, and I am very grateful for your commitment today to be a cosponsor and to work with us so that we can make sure that this issue is beyond politics and that we get the very best possible resolution for the American people.

Senator JEFFORDS. I thank you for those words, and we are all dedicated to help.

Mrs. CLINTON. Thank you.

Senator JEFFORDS. First, I want to applaud your efforts with respect to State flexibility. Some might accuse me of being a little parochial in this, but you know Vermont has been working very, very hard to come forth with their own health care plan. They are concerned, though, that they may be restricted by the national plan which we come forth with. So I think success in reform and getting it approved depends upon the States being able to support it.

I understand that you have indicated an openness to change, but to what extent do you feel State flexibility is important to your proposal?

Mrs. CLINTON. I think it is very important, Senator, and Vermont is just one of several States that has shown tremendous leadership in moving ahead and really demonstrating to the country the kinds of steps that needed to be taken. So we want to maximize State flexibility.

On the other hand, we have to recognize that there are States that have been very blunt in saying they don't want anything to do with health care reform. It is not an issue they feel comfortable tackling and they don't want the responsibility. So striking the right balance between those States that really should be encour-

aged to move forward and the kind of Federal program that will be needed to ensure security for every American so that States that don't want to be move forward will be motivated to do so is what we are trying to achieve. We will certainly look forward to working with you in making sure we strike that right balance.

I personally prefer maximum flexibility. I think the problems in Vermont are different from the problems in Arkansas, and I want both States to deal with them responsibly.

Senator JEFFORDS. My final question will test a little bit of that flexibility in the sense of the State of Vermont's desires. My question is, under the Clinton plan will the State of Vermont will allowed to require that doctors be paid the same rate whether they see someone young or old or whether they work for a large company or a small company?

Mrs. CLINTON. You mean an all-payor rate system for physicians?

Senator JEFFORDS. An all-payor rate system.

Mrs. CLINTON. Yes. I was asked that question yesterday by Maryland. Maryland already has an all-payor hospital system. They are developing an all-payor physician system, and I think that that is one of those areas that we would permit States to move forward on if that is what they thought was in their best interests.

Senator JEFFORDS. Thank you. I look forward to working with you. Thank you, Mr. Chairman.

Mrs. CLINTON. Thank you very much, Senator.

The CHAIRMAN. I just want to express our appreciation to Senator Jeffords for his support. We are obviously eager to work with all of our colleagues to try and find common ground.

Senator Metzenbaum.

Senator METZENBAUM. Mrs. Clinton, as I sat here, I was thinking to myself that you and your husband are truly unique because both you and your husband are knowledgeable about the specifics of this program. I have served here with five different Presidents, but I remember the record of many other Presidents as well, and I don't remember any other President, and certainly no other Presidential spouse, that was as fully involved and fully knowledgeable about a legislative program as the two of you are.

Your husband the other evening, the President, took questions for over 2 hours, and then, as I understand it, stayed for another hour answering additional questions. I think the American people probably have not realized that you are just totally unique in the fact that you have not only said I am for this program, this great piece of legislation, I will sign it, whatever the case may be, but you know this program. You are a part of it, you helped create it, as well as did the President, and I think the American people have a right to be very proud.

As I sat here this morning and I heard my colleague, Senator Jeffords, speak, I said to myself I don't know what it is that creates Republicans of that flavor, but he follows Bob Stafford and George Aiken, and I feel very proud to have the privilege of serving with him.

Having said that, let me ask you a couple of questions. We are talking about a program that now costs about $940 billion a year, almost $1 trillion a year. I am concerned to see how we go about

consumer control, not only window dressing, but actually having consumer rights. We will have health alliances, 50 percent by employers, 50 percent by consumers, but the employers will be an integrated group in all probability; they will work together.

I am concerned about how does the consumer, really the American public, get their voice heard and have a right to control this system, not just be a party to it.

Mrs. CLINTON. Well, Senator, we believe that the principal difference in what we are proposing is that for the first time ever consumers will be making the decisions that count. They will be deciding which health plan they will join.

To go back to Senator Kassebaum's inquiry, it will be the consumer, not the employer and not the alliance and not any government agency, whether it be Medicaid or anything else, who will determine what health plan a particular individual decides to join. Every year, consumers will be, in effect, voting with their feet. If they are not satisfied with the service they got or they have met somebody that they prefer in a different plan, well, they will be able to make that decision. As a result, the ultimate market and competitive forces that we think will lead to high-quality health care being delivered most efficiently will rest upon millions and millions of individual consumer decisions. The richest person and the poorest person will have the same vote because they will each decide where they want to go, and that will make a difference in how health care is delivered.

Second, as you point out, the kind of alliance structure that we are envisioning will be governed by an employer representative and consumer representative board, with consumers having 50 percent of the seats.

I would anticipate with the kind of interest in health care that we are now seeing, there will be a very active consumer constituency in which people will be making all kinds of judgments about health plans. We will be getting information out to each other. I think we will see a lot of very positive consumer activity.

Then the last thing I would say is that for the first time consumers will have good information about quality and will be able to make decisions. That will in turn, I hope, drive the hospitals, the physicians, the insurers and others to be responsive because they will have to deliver the quality information and then it will serve as a basis for both the representatives at the alliance level and the individual consumer to make decisions.

Senator METZENBAUM. Would it make good sense to put some limit on administrative expenses that see to it that insurance companies operate efficiently?

As you know, the average insurance company administrative expenses today run about 25 percent. Medicare administrative expenses run about 3 percent and Canada has administrative costs of 1 percent. I am concerned that, whether it is Blue Cross/Blue Shield or the Prudential Insurance Company or the Metropolitan Life Insurance Company or whatever the case may be, that they all will build in a factor of high administrative costs. I am concerned as to whether there will not be enough competition to drive that down and whether or not we as legislators ought to be placing some limits on the administrative costs.

Mrs. CLINTON. Senator, I do not believe that will be necessary for the following reasons. If we reform the insurance market and we particularly reform the nongroup and small-group market, we will be eliminating a lot of the administrative costs that currently are in the insurance system. If we further begin to eliminate preexisting conditions and make it clear that people cannot be denied coverage on the basis of underwriting and determining how much of a risk that they present, that will eliminate an additional very large portion of the administrative expense that currently drives up costs within the private insurance market.

I think those two changes will have a big impact on the kinds of decisions that insurers make. They will then find it in their interest to become more efficient and to make decisions more quickly on the basis of trying to get the highest quality care to people at the lowest possible price. So, I do not think that we need to regulate that. I think the market will take care of that as we make the kinds of changes that we hope you will make in the legislation to eliminate preexisting conditions to reform the insurance market. The administrative load will go down dramatically.

Senator METZENBAUM. Thank you very much, Mr. Chairman.

The CHAIRMAN. Isn't that the case for the California public employees, too? They are at about 1.5 percent administrative costs?

Mrs. CLINTON. That is right. That is, in effect, a very large alliance. It has been able to drive a very hard bargain with the insurers who provide the services through the plans that are available to the members.

The CHAIRMAN. Senator Coats.

Senator COATS. Thank you, Mr. Chairman

Mrs. Clinton, thank you for appearing before us. I hope I am not the first dark cloud to appear on the horizon today for you. I hope what I say is not interpreted as being partisan politics because I do agree with every member on this committee and with you that there are inefficiencies and distortions in our health care system that are robbing people of care that they need. It is costing all of us more money than we ought to spend. I think we all agree that reforms are needed and necessary. The question is not whether, but how we go about doing it.

I have joined some Senators in offering a proposal to deal with those reforms that is different than what you are advocating. It is primarily different because it is based on some different assumptions. I would like to just outline four of those assumptions and then ask the question as to whether or not you think those assumptions are valid or invalid and, if invalid, why and how we might address that.

The first assumption that we are operating under is that government, for all of its good intentions, is less efficient than the private sector. My experience with government and my constituents' experience with government is that because it is not driven by a market system and does not have a profit motive, it is less efficient. I think anybody who stands 5 minutes in a post office and then goes and visits UPS sees the difference between a government-run operation and a private-run operation, if we look at the State level.

I just, in the last 2 days, have gone through the process of helping my 16-year-old son attain a driver's license. It has been a

nightmare for my wife and I to go through the lines and the forms and delays just to get a driver's license.

The second assumption that we are operating under is that the political process often, almost always, overwhelms the marketplace. Outside my office every day that we are in session, there is a steady stream of people coming to try to influence the political process saying, include our program, include our benefits. Whether it is health care or any other aspect of what government does, it seems that the ultimate decision is not a marketplace decision, but a political decision.

Therefore, we are concerned that a health plan which basically says these are the benefits that will be available will simply invite many more saying, include us. Whether it makes economic sense or not, they will try to garner enough support from the political process to be included.

Third, it is my experience and our assumption that costs that government estimates for the costs of a program are always grossly, grossly underestimated. I went back and looked at the Congressional Record for when we enacted Medicare and the projections that were listed by Congress for expenditures under just Part A of Medicare for 19—they ran those out to 1990. They said by 1990, we would be spending $9 billion a year on Part A Medicare. The actual expenditure in 1990 was $67 billion, 7 1/2 times the estimate.

So, we may estimate figures here today as associated with this health care plan. My experience is, like every other program government gets involved in, it grows partly because of this political process and the inefficiencies; it grows far beyond our estimates.

Our final assumption is that a great deal of health care expenditure is, as your husband pointed out in his speech to the Congress, caused by human behavior, choices that we as human beings make. Now, I appreciate your husband saying we must do much better than this, but my experience is that human beings react to incentives, positively to rewards and negatively to penalties.

It seems to me that any health care plan that is truly going to modify human behavior, and therefore help hold down health care costs, whether it is smoking, excessive drinking, unwarranted sexual practices that lead to disease, on and on, lack of exercise, overeating, et cetera—if we are going to affect that, we need a system of rewards or a system of penalties.

Why should someone who exercises behavior that results in lower health care costs be paying the same thing as someone who is disregarding that? Why shouldn't there be a differential?

Those are some basic assumptions on which we are basing our plan. I do not think I see those assumptions in your plan. Are my assumptions valid? If not, why are they invalid? How are we going to reconcile the differences?

The CHAIRMAN. Just before Mrs. Clinton answers, over in the House they restricted Mrs. Clinton to 2 minutes, for both the question and the answer. She had to sandwich her answer into that 2 minutes. We have developed marvelous skills here. Within our 5 minutes, we ask a lot of questions. We want to give you the assurance that you take whatever time you want to to respond to the cumulative questions of our colleagues.

Mrs. CLINTON. Thank you.

Senator COATS. Since we did not have opening statements, I thought I would slip mine in in my questions. [Laughter.]

Mrs. CLINTON. I appreciate that, Senator.

Let me start by saying that I do not know that any of your assumptions in general are wrong, but in particular, as applied to the health care system, I do not believe they are applicable. Let me run through them. In fact, what we are trying to do is to create a system in which there truly is some kind of a market and some kind of competitive pressures that will enable us to move this health care system to a much more efficient level than it currently is operating on.

Your first assumption about government being less efficient than the private sector is not true in the health care system, as it is currently structured. I think that one of the Senators earlier referred to the fact that the administrative costs in Medicare are much less than they are in the private sector. The private sector has become much less efficient in health care delivery and health care pricing than you would think it should be, but it has done so because of the kinds of incentives currently in the market.

So, for example, the heavy administrative percentage that you will find in the private sector insurance market is due to a very clear decision, which is the more money we can spend making sure we do not insure people who might cost us money, the more money we will make. So, therefore, the kind of underwriting practices and the kind of selling practices that are aimed at insuring people are aimed in part at eliminating from coverage people who might be a cost on the insurance system. For example, it takes a lot of time, manpower, and resources to choose among everyone sitting in this room who is and who is not a good risk.

If you look at the way the current private sector operates, you will find an enormous amount of inefficiency, as Dr. Koop has pointed out, not only on the insurance side, but on the medical decisionmaking side. Now, part of that is driven by decisions that are made in government as well as in the private sector. Government followed the private sector in deciding to reimburse for medical care based on procedure and on tests and on diagnosis, on the kind of fee-for-service model that we have grown up with in our country.

So in both the private sector and the government sector, with respect to health care, we do not have a real market. You will find a great deal of inefficiency in the private sector in the health care market.

Someone has pointed out recently that many of our industries have had to become more efficient in the last 20 years because of external competition. We are now producing high-quality cars in our country that are very productive and are really giving a good run for the money against our competitors. It took outside competition to come in and do that. We have to create a competitive marketplace. We do not currently have one.

The second point about the political process overwhelming the marketplace is also, in general, true and we have to be very careful about that in fashioning this health care reform. Senator Kassebaum and I have talked about this. In her bill, she puts the decision about what benefits will be covered at the level of the national

board. She does this to take these difficult decisions out of politics, so you do not have people grabbing on you as you walk down the hallway saying, include this, include that, include my favorite, particular kind of treatment.

We thought very hard about that and I had a very good meeting with Senators Kassebaum and Danforth, in which they, I thought, very clearly explained why they favored that approach. We decided that, initially, we should have the benefits package approved by the Congress, so that individual citizens could know what was in it. Then any changes to it, any enhancements to it, should be moved to the national board, as the Kassebaum-Danforth Bill had originally suggested. We do not want the political process overwhelming the marketplace and we agree with you that is something we have to guard against.

The third assumption about cost estimates by government being underestimated is absolutely right. In the health care system, cost estimates by the private sector have also been grossly underestimated. I think in large measure, you would see a parallel in the increase of government expenditures that is at least equal to, if not slightly below the increase in private sector expenditures in the health care system. Those two go hand in hand.

It is very difficult for you as a Senator to make projections about what Medicare or Medicaid will cost because what happens is you set a certain amount of money to be available in the budget. What the private sector does is to shift costs that they do not get from the budget out of your decisions onto the private sector. What the private sector consistently has done, both in employers buying insurance and insurers pricing insurance and doctors making decisions, is consistently underestimate what health care costs are or will be and, I would argue, what it should cost.

So this is an issue that is not just a government issue. This is a private sector issue. One of the reasons we want to have some market forces and some competition in this system is so that cost estimates can be made on the basis of delivering health care, not on a diagnosis-procedure basis, but on a per capita basis in which decisionmakers, insurers, doctors, hospitals and others have to make decisions so that costs will be kept down. We can no longer afford to write a blank check.

Finally, I think that there is no doubt that human choices drive health care costs, like it does in most other areas of our lives. What we are trying to do is to have a system in which everybody is part of that system because to leave some out who make bad choices is a cost to us whether we like it or not. Everyone who makes a bad choice who is uninsured drives our costs up. They will eventually cost us something either in more tax dollars or in higher insurance premiums.

If we have everybody covered and everybody in the system so that we finally can stop the cost shifting, then I think health plans and individuals will be able to make cost-conscious choices that will reward us with the benefits of their decisionmaking. I think until we get everybody in the system, then the human choices that inevitably drive up health care costs will continue to be shifted onto the backs of those who have taken responsibility for their own insurance.

The CHAIRMAN. Thank very much.

Senator Dodd.

Senator DODD. It is hard to follow that answer; that was so brilliant a response in my view. [Laughter.]

I am going to bring this back down to the real world here. First, let me respond to a point made by my colleague from Indiana—for whom I have a great respect.. He and I worked together and we would not have passed family and medical leave legislation without Dan Coats. And picking up on the point you made, Mrs. Clinton, about the bipartisanship, I appreciate you mentioning that because this committee has had great success with bipartisanship. But frankly, the analogy of someone going to their local post office as opposed to going to UPS does not work very well. The situation of a 16-year-old waiting in line to get a driver's license and a 16-year-old showing up with his parents because he has cancer or a tumor and is trying to access the medical system of this country is profoundly different.

We may have differences about how best to address this system, but I think drawing comparisons between systems where people have choices, and problems where people have no choices is completely unwarranted. And yet, I appreciate the points that were raised by the comparison.

Let me begin, as well, if I can, very briefly by commending our chairman. This is an extremely important issue. You rightly point out that for many of us here who have arrived in the last decade or so, this has been fairly new. For the chairman of this committee, this has been a lifetime commitment. His public service goes back, as I recall, to legislation by Kennedy-Korman; Long—Ribicoff, my predecessor in the Senate; Congressman Dingell's father—all of whom were deeply committed to health care. So there is a long history here.

The chairman of this committee has worked tirelessly from the day he arrived to this day. As chairman of this committee this is an extremely important day for him. We are finally going to deal with this issue. I did not want to begin my remarks and questions to you without recognizing his tremendous contribution to what we have achieved already.

Let me turn to a particular constituency that is of great interest of you, given your involvement with the Children's Defense Fund and your involvement in Arkansas over the years with regard to children. A third of the uninsured in this country are children. Of the 37 million uninsured, 12 million children have no insurance. In my State, the most affluent State on a per capita basis in the United States, 54 percent of the uninsured are ages 24 and under.

In many ways, the current system is really stacked against children. Adults arguably have some choices about where they can go. But, children are entirely dependent upon what happens to their parents. If you lose your job, you lose your insurance and so does your child. Preexisting condition exclusions deny the coverage.

And in addition, children's needs, particularly in the preventive area, are different from adults.

Again, I am preaching to the choir on this particular issue. I do not think there ought to be too much debate here about our common determination to see to it that this constituency, the most in-

nocent in many ways, gets the kind of proper care and coverage, that they lack under the present system. As I said at the outset, it is stacked against them.

You rightly talked about women at the outset of your remarks. I wonder if you just might spend a couple of minutes focusing on children. Children do not have lawyers. They do not have the right to vote. They do not make campaign contributions. My fear in this debate is that they are going to be left aside and brought in as an after-thought. I hope that is not the case. If you could just spend a couple of minutes addressing that particular constituency, I would appreciate it.

Mrs. CLINTON. Well, Senator Dodd, I would be happy to. I want to thank you for never forgetting that constituency and the work that you have done over the years to make sure that children's needs are not forgotten. I suppose, on an emotional level, it is the most important thing to me. I don't know that anyone can look into the eyes of a child who is sick and has been made sicker because costs kept a parent away from getting care when needed, without feeling that there is something seriously wrong with the way we are taking care of our children.

I don't think there are any stories that have moved me more than the stories of parents who have just given up everything in order to take care of their children's health needs. I mean, it is a bizarre situation to have a country in which there is parent after parent—and we can give you their names and their addresses and their phone numbers—who had to give up a job when they lost their insurance, whether it was taken away from them because of a child's illness or whether it was priced so high that they could no longer afford it, to go on welfare to be able to take care of their children's medical needs. That is absolutely the wrong message. It is the wrong message that you have tried to send, that Senator Coats with his work on behalf of children has tried to send and it is something we have to end.

I think that one of the great benefits that we will have from health care reform is insuring the kind of primary and preventive care that all children need to be healthy. We will cover vaccinations. We will cover well-child care.

I have to confess, like many people, before I had children, I didn't think about what my insurance policy did or didn't cover. I remember the shock I felt when I realized that my very good insurance policy would not pay for the well-child exam. They would pay if Chelsea were sick and I brought her to the hospital for some kind of treatment, but they would not pay for me to make sure she was kept well. I thought that was absolutely backwards then and I still believe it is. So if we emphasize primary and preventive care for children, then I think we will begin to reverse what has been a neglect of our children in our health care system.

We need to insure that no parent, whether that parent loses the job that they had or cannot find a job or whatever their circumstances might be, will have to worry about taking care of their children. If we do, we will once and for all end this travesty of having people give up jobs to go on welfare to be able to take care of their children. It is one of the reasons why the Academy of Pediatrics supports this plan. They see firsthand every day the costs of

what it means for parents to wonder whether they can afford the x-ray that the doctor says they should have or whether they can pay for the medication that their doctor has prescribed for their child.

For years, I worked as a member of the Board of Directors of the Arkansas Children's Hospital. I have never walked into that hospital without a combination of such gratitude and also such emotion. I just do not want any parent ever to have to worry about whether or not they can afford to take care of their child. I don't have to worry about that. I cannot imagine what that must feel like. We need to end it and this would help us do that.

Senator DODD. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Mr. Gregg.

Mr. Gregg. Thank you. Let me associate myself with the accolades, which are very appropriate. The depth and substance of your responses and input on this subject has been of great benefit to this country, I believe, because it has focused so much attention on it.

Like with so many issues like this, this is complex. It is interwoven. It is a tremendous matrix, with a lot of different strings running through it. The devil tends to be in the details. I have read through the program a couple of times. I have to admit that I am not as substantively up to speed as I would like to be, but have tried to get there.

I sort of scratch my head because, in a lot of areas, the boot does not seem to fit the binding. For example, there is the desire—and it is a very legitimate one, one I support—to get significant savings in health care, $280 billion in Medicare and Medicaid making up most of that. At the same time, there is a proposal for a $91 billion deficit reduction which is obviously a good cause.

At the same time, there are five major new entitlements proposed: a drug entitlement, a long-term care entitlement, an early retirement entitlement, the entitlement to everyone who does not have health care now, and a small business entitlement, which is a huge one in the benefits package.

My experience with government tells me that if you are putting in place entitlements of those sizes, with those costs, you are going to drive up costs. You are not going to be able to control costs, and the savings which are desired and legitimate and you are trying to attain will be very hard to realize. So, there, the boot does not fit the binding.

Second, there is the issue of flexibility, which is, again, very important. I know that in your husband's role as a governor, he was totally committed to States' rights and to making sure the States had proper power. Governmental States' rights and simplicity are very appropriate roles.

I look at this National Board and the power which is being laid at the feet of this National Board is awesome, especially in its relationship with dealing with the States. I made a list of the powers, and I know you are familiar with them, but they go on considerably and they are all extremely substantive, from the capacity to control the structure of the alliances to the capacity to set the premium the alliances deal with. Really, when you look at this National

Board, as I see it, it is probably going to be more important to get on the National Board, the seven-member board, than to get on the U.S. Supreme Court of the United States. That is the level of influence that this Board is going to have in driving health care policy, especially at the State level.

So I don't see the flexibility and I don't see the simplicity. I see, rather, an organization that is dominant at the center, to the detriment of the States' capacity to have flexibility. So I don't see where those fit.

Then there is this whole question of competition, which is the way you drive down costs. You certainly have spoken about that this morning, but underlying this competition, you have stand-by price controls. You have a proposal which basically is global budgeting—in the capacity of the National Board to review the premiums that are set. You have the question of the National Board itself, which essentially, to simplify it and to characterize it, is a nationalization of the health industry—to take 14 percent of the American economy and put it under the control of that Board. So I don't see that competition exists there.

The States have flexibility only to the extent that they basically follow what the Federal Government's guidelines are. If a State wishes to do something other than a health alliance, if a State wishes to do something other than single-payor, then as I understand it, that flexibility is extremely limited.

So the debate here, as I see it, is not over universal coverage or security. Those are goals I accept. It is not over the well-child programs or primary care. Those all have to be in whatever package comes through. As I see it, the debate here is over whether or not there should be universal control centralized in the hands of a few to the detriment of the many, the many being the States and the legislatures and the governors and the people in the local communities who traditionally have made these health care decisions. I guess my question goes to this issue.

As I understand it, the powers that lie here are if a State does not come forward with a plan—and you alluded to this earlier—which conforms to Federal guidelines, which was the phraseology I believe you used, then the National Board deems that the State is not in compliance. Then they tell the Secretary of Health and Human services this, and she then has the power to withdraw from the States all financial support that is going to the States and all functions which Health and Human Services deal with.

Second, the National Board then has the authority to draft a plan for the States and institute it. Third, the Secretary of the Treasury has the authority to unilaterally, without even Congressional approval, as I understand it, assess a tax on business activity within the States.

Are those three powers appropriately described? If they are not appropriately described, could you give me your definition of them—in regard to the National Board's decision that a State is not in adequate compliance?

Mrs. CLINTON. Well, Senator, we view what you have just described as an absolute last resort. The only reason that it is even in there is because, very honestly, there are some States that have told us privately that they will need the Federal back-up enforce-

ment provisions to successfully implement health reform. They are not yet ready to do it by themselves. Then there are other States, like Vermont, Florida, Washington, Hawaii and Minnesota, that are chomping at the bit. They can't get there too soon.

So what we are trying to do is to give as much encouragement to States as possible and we will enhance the flexibility, as I mentioned to Senator Jeffords. Any ideas that you have and, particularly I would welcome yours as a former governor, that would give States that kind of flexibility, we are ready to look at and to extend.

This is a federally guaranteed program. We do want every American to have access to the same benefits. So if you live in New Hampshire, you have them and if you live in Arkansas, you have them. If we have a State, for whatever bizarre combination of reasons, that doesn't want to do anything—they don't want to make their own choices, they don't want to do what Maryland has done or what Minnesota has done, they don't want to guarantee the benefits package to their citizens, then we believe there has to be some fall-back position.

Now, I think it is highly unlikely. I cannot even imagine a political circumstance in which a State would not be willing to do what it needed to do and, given flexibility, what it thought was right for itself. This is not a program like some programs in the past where only a few people have been affected by them. This is a program that will affect everyone.

So I imagine that the political situation in most States will lead every governor I have ever met and every State legislature I have ever heard about to do what they think is right for their State. In the event of some unforeseen circumstance where a State refuses or is unwilling to do so, we do think there needs to be some kind of enforcement mechanism, so that if you live in one State, you are not denied what you would have if you lived across the border or in any other State. That is the only reason that is in there. We honestly don't see it ever coming into play, but we needed something there as—going back to Senator Coats' example, as a kind of stick as well as a carrot.

If there are additional ways that you would like to see State flexibility considered, if there are additional ideas that you think would meet the basic requirements of providing universal coverage in a State and doing it in a way that is appropriate to a particular State, we welcome that. We want to hear more about that.

Let me just say a final word about the national board. The national board is meant to be a coordinating and advisory board. If the way we have described some of its functions sound too regulatory, we want to take a look at that. That has not been out intention. It is mostly there in a kind of monitoring advisory capacity. We will be happy to sit down and go through the very specific powers and to talk about why we think they are necessary and to have your response to that.

Mr. Gregg. Thank you.

The CHAIRMAN. Senator Simon.

Senator SIMON. Thank you, Mr. Chairman.

We thank you for your leadership, which has, I think everyone agrees, been superb. Let me also join Senator Dodd in thanking the

chairman, Senator Kennedy, for his yeoman work through the years in this field. We are all grateful to him.

You mention in your opening remarks this room, where we have had many historic gatherings. One thing is different. In every other involvement here, the Democrats were over there on the left and the Republicans were over here on the right. I hope it is significant. Democrats are moving to the right. Republicans are moving to the left in this room. [Laughter.]

To my colleague, Senator Pell, who brought up the question of violence in health, I would be happy to join him—and if we need additional revenue, let's have a 25-percent tax on handguns and a 50-percent tax on assault weapons. We would be helping the health of this Nation in more ways than one. So, Clai Pell, if you want to move in that direction, I will join you on that.

One word for all of my colleagues, as well as those in the administration. I think it is important that we move expeditiously here. If this drags on too long, people are going to look at and focus on the minutiae. They are going to distort. Absolutely, we ought to hold hearings like this, and we will hold plenty of them. The chairman this morning was talking about 29 hearings. Let's focus on everything we should, but let's move and move rapidly so that we give the American people what they are entitled to.

You opened your remarks talking about research. There are those who say, in the pharmaceutical industry, that this is going to hurt research. There are those in the university community who are concerned about the research aspects. I would be interested in your response to their concerns.

Mrs. CLINTON. I can understand those concerns, Senator, because this has been an issue that we have really struggled with. We have tried to balance what we consider the necessary kinds of investments in research and development that we want to see biotech companies and pharmaceutical companies pursue, as well as other research that is perhaps located on our campuses.

With respect particularly to pharmaceutical and other kinds of research, we have a dilemma. There are some in this body, as you well know, who believe that pharmaceutical pricing has been unjustified, much too high, not related to a return on the investment into the research and development of the products. There are others who believe that it is one of our most profitable industries and that it has been a great boon both in job creation and in bringing down medical costs and human suffering. They believe that it is only fair for those companies to realize a good return on those investments. Both are probably right, both positions.

What we have got to figure out how to do is to encourage research, make sure there always is a fair and profitable return on the investments in research, but not permit the kind of pricing that has caused our drug prices to rise at three times the rate of inflation and causes drugs that are produced in this country with a combination of government-funded research and private research to be sold at less of a cost overseas than they are sold to the taxpayers who paid for the research.

So we have tried to strike a balance. That balance would ask that as we move forward with prescription drugs being available to Americans, which will put more money into the pharmaceutical in-

dustry, that Medicare, for example, be permitted to have a discount on the price of those drugs. We think that that is a fair request for the kind of dollars that will be going into drug companies.

We also think with respect to breakthrough drugs, there ought to be some review of pharmaceutical pricing and then the publishing of information about those drugs that would be widely available to consumers, and institutional purchasers of prescriptions. This review process would have no authority to regulate the prices of drugs and we suggest it not to chill the development of drugs or their marketing, but to make available information about what their real costs are and what their efficacy is as anticipated by the research.

I mentioned yesterday, and I am still very struck by the story I heard just a few days ago of the specialist at Mayo Clinic who discovered that a pill that is used to de-worm animals is useful in helping people with colon cancer. He teamed up with one of our major pharmaceuticals and they did the research together. It was not, as he described it, very complicated research. It was merely to make sure that the components in the drugs used for animals were safe for humans and that it would have a good effect on humans.

At the end of this work, the company began to manufacture the drug and the only difference, as he described it, in the drug was that it was made smaller because sheep has to swallow a bigger pill than the rest of us do. Well, the net result is if you went into a vet or you went into an animal feed store, you would buy that pill for 6 cents. If you wanted to prescribe it for your patient for colon cancer, it would cost $6 a pill.

Now, this physician said that he had always been a strong believer in the use of pharmaceuticals. He had been a strong supporter of the pharmaceutical industry because he had seen with his own eyes what miracles can be done. He could not for the life of him understand what the costs were that would permit that company to recover that kind of profit on that particular pill.

So that is the kind of concern we have. How do we get to market with good research, supported research, the kind of cost-effective pharmaceuticals that our people need? How do we ensure that our pharmaceutical industry continue to grow and be productive? How do we be sure that we get good value for the dollars we spend? So that is how we have tried to balance that.

Senator SIMON. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Senator Thurmond.

Senator THURMOND. Thank you, Mr. Chairman. Mr. Chairman, I would like to join my colleagues in extending a warm welcome to the First Lady, Mrs. Hillary Rodham Clinton, an able person who is dedicated to improving the health care of our people. Ms. Clinton, it is a pleasure to have you here this morning.

Mr. Chairman, we all agree that our health care system needs comprehensive reform. However, while we attempt to address the problems of our health care system, we need to preserve the successful parts of our present system. As you know, America now has the highest quality health care system in the world. We need to maintain the quality of services for the 85 percent of Americans

who currently enjoy health care coverage and cover those currently without a health care plan.

Mr. Chairman, I believe that we should insure that coverage is available to all Americans. We should not allow the cancellation of health care coverage because of illness, nor allow coverage to be denied because of a preexisting condition. Further, I believe that coverage should be portable. If some individuals lose their jobs or decide to change jobs, they should be free from the fear that they will have to take a reduction in the amount of health care coverage or that they may lose it entirely.

We must preserve the ability of Americans to choose from a variety of health care plans and to choose their primary physician. We should provide patients with information that will them make cost-effective choices by providing patients with this information and the ability to choose. We will encourage competition and raise the quality of care provided.

Mr. Chairman, if we provide information and incentives concerning preventive health care, I believe we could prevent many of the health care problems we have today. Each of us must take responsibility to practice preventive health care. Proper diet, reasonable exercise and an optimistic attitude toward life promote health. The savings incurred by practicing preventive health care are not easily measured, but surely they are cheaper in cost and suffering than practicing curative medicine. I strongly suggest that serious consideration be given to including preventive health care in any program that is adopted.

Finally, Mr. Chairman, the cost of health care planning is the number one health issues to Americans according to the Wall Street Journal. Americans do not want their health care costs to rise and the quality of health care to diminish because of sweeping new government controls over the health care system. We must find some way to pay for these reforms without an undue burden on business, the taxpayer or others.

Again, Mr. Chairman, I would like to welcome the First Lady here today. Mrs. Clinton, thanks for your testimony and I look forward to working with you to address the health care problems facing America today.

I have two questions. If time will permit, I will just ask one. Mrs. Clinton, some antitrust experts in the health care field compliment the recent DOJ-FTC statements of antitrust enforcement policy as being useful and clear summaries of existing enforcement policies. However, the antitrust experts are concerned that the policy statements do announce a significant change occurring in antitrust enforcement policies.

The question is, do you contemplate that additional policy statements from the enforcement agencies will be forthcoming or will the other antitrust adjustments be necessary as part of health care reform?

Mrs. CLINTON. Thank you, Senator, and could I just say amen to your opening statement. I thought especially the emphasis on primary and preventive health care is absolutely on target. You are a living example of that and I hope everybody will pay attention to you. [Laughter.]

Senator, we did believe that we made some progress. We want to particularly thank Senator Metzenbaum and Congressman Brooks for their support for the statements that were made by the Department of Justice and the FTC. We are still concerned that physicians do not know whether or not they can join together to become accountable health plans either on their own or with hospitals and we do want to clarify that. I think it is very important that doctors around the country feel they have the same opportunity to offer an organized health plan to their communities as insurance companies or HMOs currently do.

So we are still looking at that. We are working with the AMA about that. We are going to try to clarify it. If we think any clarifying legislation is necessary, we will be recommending that and we would welcome any ideas you have as to how we could achieve our common goals about the antitrust enforcement so that we can have a health care system that really is competitive.

Senator THURMOND. Thank you very much. I don't have time to ask my second question. I will submit it for the record.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Mrs. Clinton, Senator Harkin, as you know, is the floor manager for the HHS appropriations legislation and is on the floor and has been there all morning, and he deeply regrets he couldn't be here.

Senator Mikulski.

Senator MIKULSKI. Thank you very much, Mr. Chairman.

Mrs. Clinton, really, a cordial welcome here today. I believe you are the third First Lady in American history to come before the United States Congress and offer testimony on social policy. The other two First Ladies who came offered comment on a policy initiated by others, but I believe you are the first First Lady to come who is actually the architect or the chief architect of a plan.

I would like to compliment the President for attempting to achieve a national goal of safety and security for all Americans in the area of health care, and the effort that you have made in taking that national goal and now trying to operationalize it into a health plan.

It is not easy to operationalize idealism. It is not easy to operationalize noble intentions, but I believe that you and the President have undertaken to do that, and I think we see it reflected in the plan that you have put forth here today. You have taken the ordinary stories of people and translated them in the most significant public policy initiative in three decades.

I think all of us owe accolades to the core benefit package that has been established that emphasizes prevention, primary care, and personal responsibility, and understanding the needs of women, children, and the elderly. The fact that our conversation is focussed on so many details is a tribute to what is already agreed upon in the conversation, particularly related to the core benefit package and the emphasis on those three areas.

My question goes to picking up on the health alliance. I truly believe that what you want to achieve is a combination of marketplace discipline, and yet allowing mission-driven plans focussing on those ideals to go into place.

I am concerned, Mrs. Clinton, that with the health alliance, they will be able to choose the plan, and I am concerned if the criteria is solely or primarily cost, the cost of the plan, mission-driven plans, those that are primarily operated by nonprofits, those providers that serve either urban areas or rural areas that will by the very nature of who they serve be high-cost, be pushed aside, and that it is not that we will have too little of marketplace activity or too little competition, but we will have too much, and that instead of having a community of health care, it will all be focussed only on the marketplace.

Could you comment on that?

Mrs. CLINTON. That is a very important question, and as you were talking, Senator, I was thinking back to our morning at Jimmy's Diner and all of the people who told us their stories, and every one of those was a responsible, tax-paying, hard-working American citizen, every single one of them, and every one of them was having trouble affordable health care that would be available to them.

I think it is important that we have a system in which many different kinds of health plans can compete, but I guess I see it a little bit differently. I see the mission-driven, which is a wonderful phrase, health providers being more than ready to step into this system.

Let me just give you a few examples of what I mean by that. If you look at our plan, it is remarkably similar to the plan put forward by the Catholic Hospital Association. The Catholic Hospital Association worked for 2 years before my husband was even elected President and came up with a plan in which they talked about having networks of health care providers competing for business that would be provided to people in their communities.

If you look at the Catholic Hospital Association, they have been providing health care of high quality often under very difficult financial circumstances in many areas that nobody else wanted to serve. They are certainly mission-driven.

Under our system, they will be advantaged because they have taken so many charity cases. They have provided so much uncompensated care. They have provided care in inner cities and rural areas where there was a very large uninsured base that couldn't compensate them for their services. Now all of a sudden they will be getting funds coming in through reimbursement that will enable them to be even more competitive.

I will give you another example. If you take the Mayo Clinic, it is a multispecialty, nonprofit clinic. Doctors are on salaries. They make the decisions about how they provide the care. They provide care at a cost that is much less than many other sectors of the health care economy because they have made decisions about how to be more cost-effective, high-quality providers.

So I think there are many examples around the country where the mission-driven, those who have made decisions to provide high quality even when they don't get compensated, like many of our Catholic hospitals, are going to be extremely well-positioned to become health providers to many more people.

Now, in order to assure that, these networks are going to have to be created with sensitivity to the populations to be served. We

are hoping that, going back to Senator Thurmond's question, we will remove whatever antitrust and other kinds of problems that are in the way of doctors and hospitals banding together. If we achieve those goals, more providers will find it profitable, will find it possible to stay in business and provide health care because we are going to insure the uninsured and we are trying to provide health care coverage where before there was none.

I guess the final point I would make about that is that I have seen in my discussions now a growing awareness on the part of many of the large hospitals and large insurance companies about these issues. They now realize that if they want to compete for the business of everyone who now can buy health care through the alliance, they are going to have to make partnerships with community health centers with that inner-city Catholic hospital, with those minority providers who are the traditional providers in an inner-city area.

So I actually think these partnerships will further enhance the opportunities for those who, up until now, have been kind of pushed into the corners of the market because they weren't able to be competitive because they took on more people and cared for more people who couldn't pay an adequate reimbursement than maybe some other providers have.

Senator MIKULSKI. Well, thank you for the answer to that question. It is reassuring to hear that, and we look forward to further discussion.

You exactly identified those facilities that I am most concerned about: the Catholic hospital, like Mercy in my downtown Baltimore; Sinai Hospital, which is undertaking care to inner-city people and new immigrants and Soviet Jews who have refugeed in this country and so on.

I would like now, if I could, to change to the issue around the elderly. There was some talk about Medicare Part C and the preserving of long-term care. You and I both lost our fathers to wrenching situations, and then as you know many families have had to spend down to qualify for Government help. So, while there has been family responsibility, the cruel rules of Government have often pushed people into family bankruptcy.

I wonder where you see the plan heading in terms of providing a safety net for long-term care that does provide for family responsibility, but does not set people up for family bankruptcy.

Mrs. CLINTON. I don't think there is any issue that I hear more about from both older people and people our age whose parents are getting into situations where they need some kind of continuing care.

We have a couple of parts of this proposal that I think will help. One is that we want to extend long-term care coverage by making sure we have got in place the services that older citizens need, and so to that end we want States to develop more home-based care and community-based care that will be reimbursable and will be much more available.

We also want to raise the spend-down limit, so that families don't have to impoverish themselves to the extent we require now before they are eligible for nursing home care.

We want to provide reimbursement for sub-acute care at nursing homes rather than in the much more expensive hospital setting.

If you take these various pieces, you can see how each meets a need that is not met now. Starting with home-based care, we do not provide the kind of financial support that many families would need in order to keep an older relative at home, and it is a very penny-wise-and-pound-foolish policy as well as one that I think is unfair to families.

If a family wants to take on the responsibility, some little bit of help, whether it is a visiting nurse or some other person to come in to help or provide respite care, we need to provide them access to these services. They are much less expensive than having someone go into a nursing home.

With respect to community-based care, I would only repeat the example that I saw the first time I visited an adult day care center in the last 9 months. It was at St. Agnes Hospital in Philadelphia. That hospital wanted to provide a service to the community. So they told families that if you keep your older relative at home, but you both work during the day, then bring them to the hospital. We will watch them during the day. If anything happens, we will be able to provide medical care.

Well, the hospital had to charge something, and the hospital tried to keep the cost as low as possible, but they had to charge about $35 or $40. Well, that is about $200 a week for a working family. That is more than most working families can afford to pay.

So the net result was that, because there was no reimbursement help for working families, most of those families according to the St. Agnes medical staff were forced to put their relatives in nursing homes which then cost the State and the Federal Government much more than maybe helping to support a $35- or $40-a-day charge.

Then, finally, with the sub-acute care, many older and disabled patients, patients who are under very severe medical conditions and often on life support, are kept in hospitals because if they are moved out of the hospital, Government assistance for their care stops.

I did not have to face that issue with my father, but I would have if he had not died. So, all of a sudden, what you think you have available in terms of financial assistance ends, and many doctors have told me, as favors to families under great financial and emotional stress, they keep patients in hospitals far longer than they should because they know to discharge them to a nursing home or discharge them to home is an unconscionable psychological and financial burden on many families.

We need alternatives to that, and providing this kind of long-term care, reimbursing for sub-acute and maintenance care, will help so many families, and those are the things we want to provide.

Senator MIKULSKI. Thank you very much, Mrs. Clinton, and thank you for the kind words you said about the Maryland program.

Mr. Chairman, I have a statement for the record.

The CHAIRMAN. It will be so included.

[The prepared statement of Senator Mikulski follows:]

PREPARED STATEMENT OF SENATOR MIKULSKI

Good morning Mrs. Clinton. It is an honor to have you with us today, and it is an honor to be a party to these deliberations.

I think that the President, working through you and your task force, should be commended for taking on this issue and dealing with it in such a comprehensive and well considered manner.

Some people see this issue as too complicated to solve. But I think this is what we were all sent to Washington to do—to deal with problems as important and difficult as this.

We are, of course, dealing with a huge issue here: it consumes one-seventh of the American economy; there are entrenched special interests all around; and this is an issue that touches people where they live—the health and well being of their families.

And there is no question that we have a crisis on our hands: exploding costs and all that means in terms of access to service and trying to stay competitive in the world marketplace; and fear of losing coverage and the financial ruin associated with a medical need.

This is not the America we have known, much less the America we aspire to. People who play by the rules—work hard, pay their taxes, serve their country when called upon—end up without life or liberty or a chance at happiness because of a medical emergency or medical condition.

If we don't reform this system, if we don't help to solve this problem, if we can't figure out how to make this system work better, we will have failed more than this task, we will have failed our country in a time great need.

I want to work with you and the President on how to improve this plan, and I the will do everything I can to make sure that the President is successful in achieving comprehensive health care reform.

So we've got our work cut out for us, and in that regard I believe all Americans owe you a debt of thanks for the leadership you have provided on this problem.

Before this plan was announced I decided on a set of principles to use to guide my deliberations on this subject. I am pleased to tell you today that this plan does pretty well in terms of those principles.

This plan makes health care accessible, affordable, and controls costs. It also goes a long way to eliminating the hassle.

Providing all Americans with a comprehensive set of benefits regardless of pre-existing health conditions, job changes, moves or—God forbid—actually getting sick or becoming disabled, would in itself be a remarkable achievement.

Let me tell you what else I like: the universal coverage and preventive care elements are a major plus, as is the support for the network of health clinics that have traditionally been there for the underserved—it is not enough to provide a list of covered services, you have to have the community infrastructure to deliver those services; I'm also pleased with the new benefits for senior citizens, the addition of prescription drug coverage under medicare, and community and home based long-term care benefits; I like what I see for women—breast and cervical cancer screenings, reproductive health services and so forth. But we need to make sure these serv-

ices are comprehensive; and finally I'm pleased about the fact that people will continue to have the right to choose which health plan to join and who their doctor will be.

But, as I said I want to be up-front about my concerns, and I do think this plan can be improved.

I'm concerned about financing—I am worried about the size of the cuts in medicare and medicaid, and I'm worried about the impact on small business.

I need to learn more about what hospitals and health care providers think about whether this proposal promotes an improved quality of care.

I'm concerned about a provision which will weaken quality control in clinical laboratories, the frequency of some tests (PAP and mammography, and the lack of specifics in the area of family planning and pregnancy related services.

My ultimate test for this plan will be how well it serves the people of Maryland, and I plan to spend a considerable amount of time talking with and listening to the people of Maryland to find out what they think about this plan.

But above all else I'm concerned about the consequences of doing nothing.

We simply can't afford the status-quo.

And its not just the health of our people at stake, its the health of our economy as well.

In 1980 Maryland companies spent $1.15 billion on health care for their employees.

Twelve years later that number is fast approaching $4 billion (up more than 250%). If things don't change it will hit $8 billion by the year 2000.

No wonder its tough to compete in the global marketplace.

So while I don't think we are there yet, and I see a need to hear from my State, I am prepared to go to work on this subject, to roll up my sleeves and work with you on this most important issue.

The CHAIRMAN. Very good.

Senator Hatch.

Senator HATCH. Thank you, Mr. Chairman.

Welcome to the committee, Mrs. Clinton, and I just want to say it is always good to be with you and always good to see you again.

I also want to thank you for elevating our Nation's dialogue on these critical health care issues, and I think you have done that single-handedly. You and the President have clearly done your homework on this issue, and you deserve a lot of credit in my opinion for your hours of study and your eloquent defense of the administration's plan.

So I, for one, personally admire you for getting into this battle and doing what you have done, and I want to work with you on this.

I agree with all of the principles for reform which the President articulated last week. We do need to provide health security for our citizens. We do need to reduce cost. We do need to reduce bureaucracy. We do need to eliminate fraud and greed. All of those are important, but the problem is we don't need to create more problems than we fix, and that is what people are worried about. With the massive sweeping changes the administration is proposing for our

health care system, it is a matter of great, great concern to a lot of us.

It is no secret that I have some problems with the administration's approaches to health care. For example, I don't believe that we need a national health benefits board to determine what health care should be in this country. I believe more employer mandates would be devastating to job creation, and, of course, there is always the question of how are we going to finance this beast.

These are very, very tough issues, but I look forward to seeing the details in the administration's plan when you get it done, hopefully within the next couple of weeks, and as I have said before, I want to work with you and help you to the extent that I can. I am afraid there is a lot of work to do no matter what or how we look into health care reform.

Maybe I would just ask one specific question, and that is this. I know this sounds trite, but price controls didn't work in the 1970s, and I don't think they are going to work any better now. Obviously, we all want to get health costs under control.

I raise the same issues that you have already discussed with regard to innovation and technology, but I am afraid that global budgeting is going to result in rationing, pure and simple. In order to control cost, you simply have to control volume as well in order for it to work.

So I think it would be useful if you could walk us through exactly how the global budget would work, explaining how the costs are going to be restrained without reduction in quality of care, choice, access, or technical innovation.

Let me just say this. One of my friends, a really great author in this country who is a doctor, an internist, Robin Cook, wrote Coma and the recent best seller, Terminal. He is writing a new novel that should come out before the end of this year which will show the horrors and the nightmares of global budgeting and Government management of health care. I think we will all want to read it because it will be right in line with what we are discussing here today.

I know you are concerned about those matters, too, but if you would, walk us through how the global budget would work, explaining how we can constrain costs without reductions in quality of care, choice, access, or technical innovation, etc.

Mrs. CLINTON. Senator, that is obviously one of the key issues, and let me start by saying that the term "global budget" is really a misnomer because there is not any intention to in any way budget every health expenditure that any American would make. The budget we discuss in our proposal would only apply to the guaranteed benefits package. Anything over and above that, anything that any individual wished to spend is clearly available for that individual to do. The marketplace will be there for individuals to take advantage of.

With respect to trying to provide some budgetary discipline with the delivery of the guaranteed benefits package, we are operating on the basis of several beliefs about the best way to do that, that I would like to share with you.

The first is that rationing already takes place in our country. It happens every single day in every single community, and it is done

by removing people from the insurance roles. It is done by putting barriers to access. It is done by making it much more difficult for some people to pay for their health care than for others. The net result is that many people are already suffering the effects of rationing because we have a kind of nonsystem of health care in which those of us who are able have access to the very best health care in the world. However, if we compare ourselves to some of our competing countries on many health indicators, we do not do a very good job for our entire population. So rationing is already happening, and, in fact, what we want to do is increase the market and increase the competitive forces that will make health care more available to the entire society.

The second point is that there has now been some very convincing work that illustrates the stark differences in health care delivery and costs that exist from one part of our country to another, and a number of people have been studying this.

This is what Dr. Koop has been doing since he left being surgeon general. He and Dr. Wenberg at Dartmouth are two of the leading researchers in this area.

If you have, as we currently do, just one of our programs, take Medicare, a 300-percent differential between the delivery of care in Miami, FL, and the delivery of care in Wisconsin, or, as Senator Durenberger never tires of pointing out to me, a 100-percent or 200-percent differential between Minnesota Medicare delivery and a place like Philadelphia, with no difference in quality that anybody can point to. These differences point out very clearly that there is a huge amount of inefficiency in the way we are delivering health care right now.

Now, if health care has been delivered at one-half the cost in New Haven, CT, compared to Boston, MA, or one-third the cost in Wisconsin compared to Miami, FL, or many other examples I could point out to you, why hasn't the whole market figured out that they can delivery health care more efficiently if they followed what Minnesota has done than if they follow what another community has done? Well, that is because, going back to Senator Coats' example, we don't have any incentives; in fact, we have got the wrong incentives in the health care system as it is currently structured.

We reimburse on a basis of diagnostic treatment, on procedure, not on the basis of what is the quality outcome that will be delivered for a particular population.

I showed it yesterday, and I have it, I think, again today. This is a consumer guide that makes the point better than I could. It's called "A Consumer Guide to Coronary Artery Bypass Surgery." It is put out by the Pennsylvania Health Care Cost Containment Council.

What Pennsylvania has been doing for a number of years is going to every hospital that performs coronary bypass surgeries, finding out how much they charge and what happened to the patient, how many died, what kinds of recovery and other problems did they have. In that one State, you can get the same operation for $21,000 or $84,000. There is no difference in quality. In fact, if you look at this consumer guide, the hospital that is delivering the surgery for $21,000 is doing as good or better a job than hospitals delivering it for 3 or 4 times that amount.

There is no current incentive in our system to move any other hospital in Pennsylvania to close that gap. We think by creating a market-driven competitive system and by providing good consumer information, we will begin to see hospitals get those costs more in line with each other. So, in fact, instead of rationing care, if more hospitals in Pennsylvania delivered a high-quality coronary bypass at $21,000, you would have more people taken care of than you do currently when the cost is $84,000.

The way we view the budget is as a backstop. It will not come into effect in the vast majority of cases because we believe that good information and decision-making on the part of providers will begin to move this system in a more rational way, so that we will have better quality health care for less money.

So the budget is there not to be imposed, but to serve as a saving guarantee, and I know my time is up, but we could go through very technically and explain how it would be enforced in the event that it should be triggered, but we really don't believe it will be triggered in most instances if people pay attention to what we know is out there about how to provide quality health care at less cost.

Senator HATCH. Thank you.

Thank you, Mr. Chairman. That is all I wish to ask today.

The CHAIRMAN. Thank you very much.

Senator Bingaman.

Senator BINGAMAN. Thank you, Mr. Chairman.

I will join all the others in congratulating you, Mrs. Clinton, and the President for your leadership and also Senator Kennedy for his long record of leadership on this issue.

I wanted to ask you about the cost containment part of it because I know that is central to your plan. I introduced a bill last year based on work that the Jackson Hole group had done, and a central part of what they proposed and what I proposed in that bill to contain cost was a limit on the amount of the employer's contribution which would be tax-free to the employee.

I know that Alan Enthoven has continued to urge that that be considered in this plan. It does seem to me that if I have a choice of a high-cost plan that perhaps is doing bypass surgery at $84,000 a crack and a low-cost plan that is doing bypass surgery at $21,000 a crack, we ought to build all the incentives in we can for me to choose the low-cost plan.

Making me pay tax on the increased cost of going to the high-cost plan would, I think, be a strong incentive. What is your thinking for not including that in what are you planning to propose?

Mrs. CLINTON. Well, Senator, let me start by saying I don't think that a restructured competitive market, where health providers are coming to get your dollar and mine and we are making the choice, will not sustain very many providers who are charging $84,000 for a bypass surgery. Providers are going to have to become more cost effective.

We are asking consumers to make cost-conscious decisions, and if I choose to join the most expensive health care plan, I will pay the difference, and that will be the choice that I make.

The issue about taxing health benefits is one that we have really struggled and worried over because we have a great deal of respect for Alan Enthoven and for the people who have worked on man-

aged competition. We believe that we have incorporated a managed competition system in many of the features that we have adopted, but we had several big problems starting with the taxing of health care benefits immediately when the plan began, and they include the following.

If you start a health care reform proposal that will affect the whole country, we know that people are starting at different levels of insurance right now. Some people have bargained for their health insurance. Some employers have offered health benefits as a competitive device to keep employees and to hire employees. So we are starting with differing levels of health insurance.

The guaranteed benefits package that we are offering, we believe is a very good benefits package, and it does emphasize primary and preventive health care. It does not, however, include some of the features that are available in insurance policies that are currently insuring millions of Americans. So to say at the very beginning these millions of Americans are going to be worse off than they would be without reform struck us as unfair.

So what we decided to do instead was to say we intend to impose a tax cap, but we want to give everybody enough notice, employers and employees, so that they can get ready for it, so that they can see how our system operates, so that they can feel secure that they are not giving up benefits that they have either bargained for or paid for in wages. So we do believe in the tax cap as advocated by the pure managed competition advocates. A tax cap will be added, but it will be several years out after the system has actually gotten up and consumers can see what the benefits are for them.

The second is that to impose a tax cap right now would be to raise taxes on millions of working Americans. I don't know how we could do that. I don't think the President feels comfortable coming to you and saying remove the tax treatment for health care benefits, and, oh, by the way, that is a tax hike on tens of millions of Americans. I can guarantee you once your constituents figure that out, you would hear a lot from them because they would think it was unfair. Our proposal does ask consumers to make cost-conscious decisions, and we have seen companies where this has worked. We have seen States where it has worked.

The State of Minnesota decided it would only pay its employer share for State employees into the lower-cost plans, and people switched. Many employers who have given lower cost alternatives to their workers have saved money because people have switched. So that is our thinking behind it.

Yes, we believe the tax cap is a tool. Yes, we want it included, but to do it now would result in a tax increase on millions of Americans which we don't think at this point in time is fair to do.

Senator BINGAMAN. Thank you for clarifying that. It is obvious you have given it a lot of thought.

Let me ask one other incentive-related question. One of the incentives that exist in the present system of health care is an incentive not to smoke. Most or at least many health care providers or plans give you a discount if you do not smoke. As I understand what you are proposing, that would not be available.

You have an assessment provision in the plan or contemplate one for employers of over 5,000 who decide to opt out. I think you

charge them a certain percentage. Why does it not make sense to maintain some kind of additional cost for individuals who choose to smoke or for employers with work forces that choose to smoke? Would that not put the incentive where you want it as we talk about responsibility in the health care system?

Mrs. CLINTON. Well, Senator, I think that we ought to take a close look at that again. We are going to propose taxing tobacco which we consider a disincentive to smoking, and we hope particularly for young people.

If there is a way without getting back into the problems caused by experience rating and underwriting practices that draw lines between people where we can just target certain very limited behaviors, we will look at that again because I share your belief that we should try to encourage wellness and discourage harmful behaviors, but we don't want to start down a slippery slope where all we do is separate young from old, healthy from sick. Once we get back into that, then we are back into all of the administrative costs and the underwriting practices that eliminate people from care, and we don't want that to happen.

Senator BINGAMAN. I agree entirely, and I think your decision to just impose the tax on tobacco products made a lot of sense. It was an exception to the community-based plan, and it might be in this other area as well.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Mr. Chairman and Mrs. Clinton, thank you.

Let me begin by saying that the people I represent like you a lot. Many of them even trust you which is very unusual for people who work in this town, and I think it is because you are one of the first national leaders to take responsibility for actually getting something done, and they feel that.

Even though they may not know enough about the plan or not trust the financing and so forth, I must say that the sense of responsibility for doing something has not been lost on my constituents.

They also appreciate your mentioning Minnesota so often. It is a unique constituency, and I have been blessed to represent it for a long, long time, and whatever I have to say by way of a question will reflect our experiences in Minnesota.

One of the things that I hope we can agree on—and I am just going to suggest one, but we don't have to do it now—is I think we need a goal for all of this that people can relate to so we don't get bogged down in all of the mechanics.

I have always used the goal of equal access to high-quality care, and a system of high-quality care through universal coverage of financial risk. I would like to add in a community commitment to the health of our citizens.

There is nothing in there about basic benefits or insurance companies or health alliances or any of that sort of thing. But it is an important measure because as we undertake this task, there are two really important things we don't have in our country today that we need to get to. One is cost containment, and the other is the goal of universal coverage.

So my question is going to be a question I have discussed with you before, and that is, why can't we do one before the other?

In order to devise an effective reform strategy, we somehow have to figure out how to get the cost under control. The reality from my experience has been that people control costs. People control costs. This is particularly true if you want to maintain high quality.

Government can control cost by putting lids on things, but then something else is lost in the system, rationing or quality or whatever. But the reality is in whatever we buy, whatever we use in our society, it is people, people that contain the cost.

Communities as markets are very, very important because communities are a series of relationships between people who have certain needs and people who can meet those needs. It is in communities where you have caregivers, in our context of the medical term, caregivers and consumers meeting on a daily basis.

So the reality is that communities across this country are containing cost. You have mentioned Minnesota. You have mentioned other States. There are employer coalitions. That is a sense of community. There are multispecialty clinics, and you have mentioned one of them, David Nexon's favorite, but there is also the Cleveland and then there is Oxner, and there are smaller ones in many of our communities.

There are efforts to increase consumer information. You mentioned Pennsylvania. However, they are all over the place. All of this is being done in communities. I need to stress this because it is communities that make the difference. It is not State Governments. Nothing that has happened in Minnesota has happened because the State Government said it needed to happen. It happened because people wanted it to happen. You have already mentioned Duluth and the difference between Duluth and Philadelphia and Wisconsin and Miami and so forth.

So the issue is really how do we spread this across the country, and what is the Government's role in all of this?

I am going to suggest two. First, the national Government ought to set the rules for a sound marketplace. If we want high quality, if we want cost containment, if we want more for less, we need to get productivity. We need dynamic markets. What are the rules for dynamic markets? It defies any logic of any experience I have had that 51 States can come up with rules for markets for products like health care and medical services.

The second part of the goal is the issue of universal access. There the Government role is probably even clearer, although even Republicans differ on this. The first role is the State role, and that is to make services available to people who can't get them from a market. Most of us who know anything about markets know that markets can get you higher quality for a lower price, but they can't do equity. They can't get doctors to go out into this part of northern Minnesota where there are only 2 people per square mile. They can't get good diagnostic equipment into certain areas. Only Government can do that.

So one of the responsibilities of Government is to make services available, and that is going to require subsidies, and that is one of the things on which State governments really ought to be con-

centrating, and they are not doing it today. They are leaving it to some medical marketplace.

The second is the affordability of the premium prices that we now pay for our coverage, and clearly that is a national issue. Tomorrow you will be before the Finance Committee, and we will talk about low income, elderly, disabled, and doing something about our policy. Before this committee, you will talk about the employer's role and so forth.

I am sort of setting up this question by saying we have to get to a market, we have to get the people to contain the cost, and we have to get the Government to make the access to the system affordable in some way.

Right now the American people as reflected by the people in my State believe that you can get to a market without universal coverage. We are doing it in Minnesota. Even though there is cost-shifting, we are moving to a market. It is happening in Utah and Oregon and in parts of New York and lots of other places. They are moving to cost containment even though there exists some cost-shifting. So I have a hard time with the notion that you have to have universal coverage in order to make a market work.

Even more important than that, it seems that we have already talked about the fact that Americans don't want their taxes raised. You have just said they don't want their taxes raised on their benefit. We all know the difficulty you have there.

Beyond that, the reason they don't want the taxes raised is they are not sure the plan is going to work. Is there not some value in demonstrating that your particular approach to markets in medicine, which no one has seen before, actually works in some communities in this country before we move to a national universal coverage system?

Mrs. CLINTON. Well, Senator, as always, you ask the most interesting and challenging questions because of your concern and commitment to this issue, and I appreciated greatly the times that we have spent together talking about this.

I guess I would answer in this way. We have seen markets beginning to work, the ones that you named. We believe we know the conditions that markets need to be able to work effectively, and we do need to define whatever the Government role is in creating that national market, so that we will have a sound and effective one.

The problem that I have in putting cost containment before universal coverage or vice versa is that in any decent marketplace, you would have people flooding to Minnesota to figure out how to keep cost down. You would have people flooding to the university in Duluth to figure out how to train more family care providers than are trained by any other medical school. You would have people lined up at Rochester, NY's boundary saying show us how you keep those costs down in Rochester, NY.

That has not happened, and it hasn't happened because there is no market there, and there is no real pressure for that market to be created by the kind of market that there would be if somebody thought they could buy a car for one-third the price in one State than they would in the other. You would have an exodus into that State.

Part of the reason there isn't is because we don't have either a good theory for cost containment with the right incentives built in that will move the market in that direction across the country and not just in the pockets where it is moving, and the other is there are all these escape valves because we don't have universal coverage. People don't feel the pressure to move because they can always shift their cost to somebody. Maybe we have States in which there is beginning to be a market, but then the neighboring State doesn't follow that example. They are still writing the blank check and they are still getting reimbursed in the old way, which is a lot easier than to come together to figure out how to make that market more dynamic.

So, from our perspective, looking at all of the factors you laid out, it seems to us we have to proceed in tandem, and I know that is a more complicated way perhaps to proceed, but we think it guarantees a better outcome. I will look forward, as I always do, to talking with you in more detail about how to fulfill the Government role that you have outlined and the universal coverage while we obtain cost containment.

Senator DURENBERGER. Thank you very much.

The CHAIRMAN. Thank you.

Senator Wellstone.

Senator WELLSTONE. Thank you, Mr. Chairman.

First of all, Mrs. Clinton, when Senator Mikulski was talking about other First Ladies that have testified, I think of my heroine, Eleanor Roosevelt, and I thought maybe a quote from her words would help you through this journey where all too often politics can be so tough and all too cynical.

Eleanor Roosevelt once said, "The future belongs to those who believe in the beauty of their dreams," and maybe I am just a romantic, but I think somehow that applies to this journey.

I am also very honored to be here, and I look at this committee hearing and your presence with a sense of history because the pricklings in my fingertips tell me that after over a half-a-century political struggle, after all that Franklin Delano Roosevelt talked about some kind of national health insurance or universal health care coverage in 1935, we are as close as we have ever been as a nation to adopt some kind of major health care reform that will provide humane, dignified, affordable care for people.

I think we have crossed the divide, and we are no longer debating whether or not we will have universal health care coverage, but what kind, and I would thank you and I would thank the President, and I would thank the Chair of this committee for that.

Now for an abrupt transition. In Minnesota, I told you that as a strong single-payer advocate, I was going to continue to press hard, and you said to me that if I didn't press hard, you would worry I was in need of health care. So, in that spirit, I will press hard.

I am going to try to do this in under five minutes. First of all, some of the concerns that were raised today, I am just going to highlight and then go to my central question. I do believe that Senator Mikulski raised a tough set of issues because when I talk to people in the cities and in the rural areas, they don't see yet the public health and the community health care clinic infrastructure,

and they are not quite sure where the poor are going to fit into these networks who are, after all, competing on the base of price, and I think that is a valid concern.

I appreciate how willing you have been to work with many of us on the mental health substance abuse, but I still think outpatient copay is too high, and I worry about that as well.

As long as we were going to talk about long-term care and I think of the people that I meet in Minnesota, I think we have to have a time certain for comprehensive package of benefits and for universal health care coverage. We can't over-promise, and we have to be clear about when we are going to come through.

Now my question. The thing that you say that is so powerful, the thing that the President said that was so powerful, is there is a card and there will be a comprehensive package of benefits, and no one can take that away, and I think we are also talking about quality of service.

Now, when we talk about quality of service, I would like to zero in on a technical point, but I think it is basic. That has to do with the average-price plan. For those who don't know what the average-price plan is about, that means that at any given State if one plan in a State or a region is 800 and another plan is 300, that 80-percent employer contribution will go to the $500 average-price plan. I am glad it is the average-price plan. That makes sense to me.

But the issue is this. It is not just a question of a package of benefits that everybody will be entitled to. It is whether that pap smear is read correctly. It is whether or not the phone call that you make is answered. It is whether or not you can make the appointment and not have to make. It is whether or not you can get into the clinic and you can be treated well.

I am worried that middle-class people might get the short end of the stick. What happens to them if in these average-price plans you do not have that quality of care and you have deficiencies? Those of us as Senators and Representatives with more income, we can buy up to a higher-price plan, but middle-income people might not be able to.

So my question to you is what do we do about that problem. Part of me says Senators and Representatives can basically participate in the same plan. Then we can monitor and make sure that it is a good average-price plan since I think it is going to be for the vast majority of people

Another part of me says let's set some limit on the differential, so that the higher-price plan can't be more than 20 percent above it, so that we don't have tiers of medicine. That is what I am worried about, and I just wonder how you respond to this concern.

Mrs. CLINTON. Senator, I think that it is a legitimate worry, and it is one that we are going to have to be very sensitive to as we move through this. The short answer is that if it is an average-price plan there should be some variety, both somewhat lower and somewhat higher, and the clearest way for a consumer to demonstrate his displeasure with a plan is not to rejoin it the following year. I don't think there is any way we can predict right now which plan will suit which consumer.

Some of the low-priced plans that are now available in Minnesota have very high consumer satisfaction. The State employee representatives with whom I spoke, who switched to the low-price plan because the State of Minnesota was not paying for higher cost plans are perfectly satisfied with that plan. I think that there will have to be on an annual basis each individual making a decision.

Now, that is not to say that some plans might be more of a financial stretch than others, and I recognize that, but until the market is really up and going, we are not going to know which plan, whether it is high-, medium-, or low-priced will be most satisfactory to which consumer.

The second point is that there does need to be some guarantee of quality. There is a difference between maybe having to wait a little bit longer in one plan and having a pap smear read wrong, and there needs to be guaranties on quality of those features that directly affect health care. That is one of the jobs that the health plan, the alliance, and all of us make certain is our top priority. We need to give consumers quality indicators and to put out report cards.

If I had a choice every year, if I got information that X-percent of pap smears had been read wrong in a plan, I would not join that plan, and that would be a very clear message to that plan that they were going to have to change what they were doing. There should be a system to intervene even before that to make sure those kinds of things don't happen.

Senator WELLSTONE. My time has run out. I have just a quick point. The problem is that there are parts of the country where within that average-price plan, there may not be another choice. Your position is that each person has a vote. My position is that that is not exactly the case because some people don't have that vote to buy up to a higher-priced plan because they don't have the income. So I want to make sure that we don't move to these tiers of medicine. I want to make sure that we shed tiers, as in T-I-E-R-S. I frankly think people in the country don't want to see that. That is my point.

Mrs. CLINTON. You are absolutely right. None of us do.

What we are trying to create, as Senator Durenberger said, is a dynamic market that responds to price and quality and gives real choice to consumers unlike what exists in many places now where there is no choice whatsoever. You don't have a low, medium, average, or high plan; you have got very little access. We want to increase that, and we are going to watch that very carefully.

The CHAIRMAN. Thank you very much.

We have one final questioner here, our good friend, Senator Wofford, who has been one of our real leaders on health care. We will hear his questions now.

We know that you have another hearing to testify at. So we will not have a second round of questions, although we will ask our colleagues if they do have questions to submit them in writing.

After Senator Wofford, if there is a member that wanted to say a very brief final comment, we would entertain that as well.

Senator Wofford.

Senator WOFFORD. Mrs. Clinton, I am happy to join Senator Jeffords and others as a cosponsor of this bill because I think it not

only reflects my own bill of a year and a half ago, but it is designed to meet the tests that the President put to us, and they were the tests that I put to the people of Pennsylvania 2 years ago.

Mr. Chairman, you have carried this ball through thick and thin over the years, and too many of those years have been thin years.

Harry Truman was beaten back when he tried to advance this ball half-a-century ago, and Richard Nixon, 25 years ago. But I believe this time, thanks to a President of the United States who is committed and to the First Lady of the land and the extraordinary work that you have done, Mrs. Clinton, we are going to take the ball across the goal line.

You won't fix the common cold, such as the one I have, but I do think that you are going to weave us together as we press hard to fix many of the major problems of our health care system.

Before I ask about early retirees and workers' compensation and possible savings there in the system, I would like to introduce you to someone behind you who helped me advance the ball up in Pennsylvania, Dr. Robert Reinecke, who is the leading opthamologist of Pennsylvania.

Robert, stand up for a minute.

He said to me when we were talking about how to reform the health care system, "Senator, we can reform the system. We can decide how if we set the goal, and I just wish you would take this Constitution to the people of Pennsylvania and say in this Constitution if you are charged with a crime, you have a right to a lawyer. It is even more fundamental if you are sick to have a right to a doctor." I took the ball from him and ran with it, and you are throwing a great ball to us now to make a reality of that.

On early retirees, I would be interested in your reminding this hearing what you are proposing there, including any comments you have on any short-term measures to stop, the great retreating sound of companies pressed by their own cost crises, withdrawing from, reducing, or canceling the benefits for early retirees.

Mrs. CLINTON. Thank you, Senator, but before I start, I must say that none of us might be sitting here if it had not been for your courageous campaign that was waged on providing health care to every citizen of Pennsylvania. Your campaign was a call that went around the country. I am just pleased that you will be part of actually delivering on that promise to your people and to the people of this Nation, and I am very grateful for the leadership you have shown on this issue.

I know of your deep concern about retirees, particularly those who are being denied health benefits which they thought they had in a sense paid for through collective bargaining agreements and through other agreements with employers over their work lives. It is a serious problem, and it is a problem both for the individual who is perhaps unpredictably in their lives denied health care when they most need it, and it is an economic problem for many of our companies which have labored under much greater costs than their competitors in trying to meet their health care needs.

We have proposed that the burden of retiree benefits of those who retire between the ages of 55 and 65 after a certain set period of work, who are not yet eligible for Medicare, be taken off of the

backs of the employer and be shared between the employers and the Federal Government.

We have costed this out at about $4.5 billion a year. We believe it is sound public policy because it does release an enormous amount of economic potential in the marketplace by taking this burden that some employers bear. The employers would continue to be responsible for a portion of the payment under their contracts or they could make some kind of lump-sum payment, but the Federal Government would pick up the rest which would guarantee health security to those individuals who are caught between their work lives and Medicare eligibility. We think this would be an appropriate kind of security to extend to them with their making the contribution as they were able and, if they went to work after they retired, they would be required to do so.

Senator WOFFORD. Do you have any thoughts on a stop-gap measure, such as the one some of us are proposing, between now and when we deliver the goods of a universal affordable health security system?

Mrs. CLINTON. We will certainly look at that. I am aware of the legislation that you have sponsored and your strong statements on behalf of that legislation. Obviously, we hope that the Congress will deal with health care reform expeditiously, so that it may not be necessary for any transition or stop-gap, but we will certainly keep that under consideration.

Senator WOFFORD. Any last words or first words on workers' compensation and how it will be included in this as a way of savings for business?

Mrs. CLINTON. We very much would like to see the workers' compensation health care benefits integrated into the national health care system. We think that would be a great benefit to small business particularly, but to all businesses that are not paying increasingly high workers' compensation premiums.

We also would like to work toward an integration of the entire workers' comp system if we are able to make adequate substitutes for workplace safety and the kinds of inducements for safety that the current system provides through the experience rating of insurance premiums in that system. At the very beginning, however, we would like to start by integrating that portion of workers' comp into the health care payment that the employer and employee would share and having the workers' comp insurers contract out with accountable health plans to deliver the kinds of health services that workers need, including rehabilitation services.

Senator WOFFORD. Thank you.

The CHAIRMAN. It will be so included.

We have recomputed the time. We find that Senator Kassebaum had 1 minute left, and it seems she has one very small question.

Senator KASSEBAUM. That is one of the advantages of being a ranking member and a thoughtful chairman. I appreciate it, and I appreciate, Mrs. Clinton, all the time you have given.

There is a witness coming tomorrow, and I would like to get your answer to this question. I am sure each and every one of us here has at one time or another tried to help constituents in our States raise money to cover costly experimental procedures, particularly transplant procedures, and have done fund-raisers and so forth.

In this case, this is a mother who has multiple myeloma, and her employer's self-insured plan doesn't cover costly experimental procedures. She has gone through all the traditional treatment protocols and they haven't worked. Her doctor is recommending a bone marrow transplant.

Would such procedures—costly, experimental procedures such as transplants—be covered under the plan as it is devised now?

Mrs. CLINTON. If a procedure is truly experimental, so that it has not yet proven in appropriate research trials its clinical efficacy for treating a certain disease, it will not be considered for inclusion in the guaranteed benefits package, but accountable health plans as they do now will certainly be free to offer any procedure that they choose to do so.

Once a procedure is still considered experimental but provable, then it may be considered by the national board to be included in the benefits package. So there will be some time lag there.

What we have been telling people, in the condition of the woman you have described, is that health plans currently make available around the country some procedures that other health plans do not. There are some that provide reimbursement for bone marrow kinds of procedures with respect to breast cancer and other kinds of cancer and other plans which do not.

We believe that that will continue to be the case, but now the consumer will be able to choose the plan that does provide that kind of treatment, so that there will be a clear, up-front commitment if we provide this service. Even though it is still considered maybe experimental and not totally proven, you or I will be able to join that or we will be able to buy in the supplemental insurance market coverage for that which is not now readily available.

So we think that the net effect will be that this woman and women like her will have much greater choice to gain coverage for this procedure before the national board were to decide it could be part of the benefits package as a matter of course.

Senator KASSEBAUM. You wouldn't appeal to the alliance? The health alliance would not make a decision regarding this?

Mrs. CLINTON. Well, the health alliance would in the first instance decide whether it was going to offer that service, and if it did, then it would be part of the benefits that the health plan itself were to offer.

What we also think would be available is the point of service option that we want every plan to offer including the closed-panel HMOs; that that would then be a referral. There might have to be some additional payment, but it wouldn't be the kind of horrific costs that now are faced by individuals who are out there all by themselves.

I would be happy, in preparation for your witness tomorrow, Senator, to have written down exactly what our procedure is with some examples and some scenarios as to how we believe it would work, if that would be helpful.

Senator KASSEBAUM. Thank you very much.

The CHAIRMAN. Just a closing brief comment from Senator Dodd.

Senator DODD. Thank you very much, Mr. Chairman.

Just very briefly, I appreciated your comments about the pharmaceutical industry. Senator Simon raised the issue, and you talked about trying to find a balance here.

I know you are aware of this. Like any other industry, there are good guys and bad guys. So, it is important to note, I think, that it takes on the average about $400 million and 12 years for a product to go from laboratory to market, and only about 1 in 5,000 actually make it from the laboratory to the market. So, as we look at individual pieces here, it can cause our level of anger to rise. But looking overall at the incredible contribution that the industry has made to the health of this country is something that I think needs to be emphasized. I raise this in a larger context, and maybe you would make a brief comment if you would.

I have listened to you countless times talk about the role of the private sector and how important it is you have said that whatever plan we develop, it should be extremely sensitive to small business in this country, and have emphasized how critical that component is to this country's economic success.

There is out there this notion somehow that this proposal is antibusiness, that it is particularly anti-small business. Nothing could be further from the truth for those of us who have listened to you and continue to listen as this plan gets developed. I wonder if you might just take a moment to comment on that particularly broad criticism that I think many of us hear from our particular constituencies.

Mrs. CLINTON. Senator, I really appreciate that opportunity. I guess I would start by saying I think it would be hard to design a system that is more anti-business than the one we currently have in which business bears the bulk of responsibility, pays most of the bills, and has until very recently had very little to say or very little control over the kinds of costs in the health care system that have increased their costs and, in many industries, lower their competitiveness.

What I believe is the fair approach to what we are doing is to recognize that business has borne the burden for taking care of most Americans. Ninety percent of those Americans who are insured are insured through their employer.

What we want to do is to build on the system and to begin to make it work for all businesses. Those businesses, large and small, that have been responsible, provided health care benefits, deserve to have some kind of cap or some kind of discount, some kind of effort made to help them control their cost because they are having such a hard time doing that. This is particularly true for small business.

For those businesses that have not insured, but who may have wanted to, we want to make it affordable for them. We are very sensitive to small business concerns. You know, my father was a small businessman. He never employed more than one or two people his whole business career. My mother worked with him. He never had health insurance for himself, his family, or his employees. It was just something that could never have been possible as the market was constructed because it was so heavily weighed against small businesses.

What we want to be able to do is to build on what works and to fix what is wrong. What is wrong is an insurance market that prices too many businesses for their insurance too high and prices others totally out of the marketplace. I think that reform will address many of the concerns that make businesses today scared to death of the insurance market and worried to death when they hear us talking about insuring everybody. They will soon realize we are talking about an entirely different set of pricing and of opportunities for coverage, and that for small businesses we are going to provide it at a discounted rate, and we are going to cap the amount that any small business has to contribute that has low wage employees and has below 50 employees.

I just don't think that we could come up with a plan that would build on what already works better than to try to bring in those businesses that don't insure at an affordable cost and bring down the cost to those who are already insuring. That is just what we are attempting to do in this plan.

Senator DODD. I thank you for that answer.

The CHAIRMAN. We have kept you beyond the time that was designated.

Are there any further comments here?

I just finally want to personally congratulate the President and you, Mrs. Clinton, for the fashioning and the shaping of this proposal, and not only for its development, but for really the momentum and in this case the bipartisan momentum which has really been created.

Obviously, there will be adjustments and changes as the legislation moves along, but I dare say that this has been really a perfect launch. If Republicans and Democrats can do half as well in meeting our responsibility, as you have and the President has, we will get a good, workable, effective program for all Americans.

We thank you very much for your presence here today. We will meet tomorrow and have hearings on the health security and savings. We have a vigorous program of hearings, as we want to learn, and we are enormously grateful to you for your presence here and most importantly for your responses and the illumination that you have given to so many different questions.

The committee stands in recess.

Mrs. CLINTON. Thank you, Mr. Chairman.

[Whereupon, at 12:40 p.m., the committee adjourned.]

SECURITY AND SAVINGS: AMERICANS RESPOND TO THE HEALTH SECURITY ACT OF 1993

THURSDAY, SEPTEMBER 30, 1993

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 1:08 p.m., in room SD–430, Dirksen Senate Office Building, Senator Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Wellstone, Wofford, Kassebaum, Jeffords, Gregg, Durenberger.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. We will come to order.

First of all, I want to express appreciation to our colleagues and our witnesses for the adjustment and changes in the time, slipping the hearing several hours. The First Lady, Mrs. Clinton, was testifying in the Finance Committee, and it seemed the better part of judgment, since the Senate of the United States was focusing on health care and health care issues, and she has an extremely important message to give, that we permit her to complete her testimony and for us to get started at the conclusion of that. So that is the reason for the change in the time, and I am grateful to our colleagues and also to our witnesses.

I'd like to say at the outset how appreciative all of us are to our witnesses for their presence and their willingness to testify. It is not easy to talk about one's needs for themselves or for their families or for their businesses, and people consider those issues as being extremely private, so we understand the kind of thought that has gone into their willingness to share their experiences with us here today.

I think the best way that we can express our appreciation is to be responsive to those concerns. I know I speak for the members of the committee, and others will speak for themselves, but we are very interested and committed to doing so.

Yesterday we heard eloquent testimony from the First Lady about the President's plan for comprehensive health reform. Mrs. Clinton emphasized the six basic principles that the President outlined in his speech last week. Two of these principles, security and savings, are the focus of this afternoon's session.

Today we will hear from six Americans about their struggle to get and keep affordable health insurance for themselves and their

families or for their workers. Each witness has a different story and a different perspective of what is wrong with the current system, but all their stories have the same two common themes: the lack of secure coverage and the exorbitant cost of health care.

Every family deserves the protection and peace of mind that comes with secure coverage. Protection must not be lost because someone loses a job or changes jobs, or develops a chronic illness, or because an employer drops coverage to cut business costs. Medicare provided that security for the elderly in the 1960's, and the Health Security Act will provide it for everyone in the 1990's.

We all know the statistics, but too often, we forget the faces behind these figures: working men and women, children, retirees, small business owners, the self-employed, all struggling to survive in a system that breaks down just when they need it most.

We intend to work with the President to fix the problems with the current system. I think the plan the First Lady outlined for us yesterday represents a solid framework for achieving this incredibly important goal.

People like Kathy and Linda, whom we'll hear from shortly, will know that no insurance company can exclude them for pre-existing medical problems or charge them more for health insurance because they have those problems.

And Joe and millions of other early retirees like him will not have to worry about losing the medical coverage they counted on when they planned their retirement.

And small business owners like Cyndy and Mike and Tomaca will be guaranteed coverage at an affordable rate.

The President's plan will ensure that there will be coverage of those particular concerns. So we'll be interested in hearing the reactions of our witnesses today on whether the President's approach is one that will meet their needs for health care security and financial protections.

We look forward to their comments.

Senator Kassebaum.

Opening Statement of Senator Kassebaum

Senator KASSEBAUM. Thank you, Mr. Chairman.

I am pleased that we have the opportunity today to hear from six individuals about their personal health care experiences and their hopes for and concerns about the directions that we may take in comprehensively reforming our Nation's health care system.

I want to personally welcome all of our witnesses. As you say, Mr. Chairman, it isn't easy, and it takes time and effort to come here and testify. And I know that it means a great deal to those watching and listening to hear this testimony, so we are very grateful for the effort that has been made to come by everyone.

I want to extend a special welcome, of course, to our two witnesses from Kansas, Linda Montgomery and Michael Braxmeyer, and Linda's husband, Richard Montgomery. Mike Braxmeyer is a third-generation owner and operator of a grocery store in rural western Kansas, Atwood, KS. He will share his experiences as a small business owner who provides health care coverage for his employees. I believe his testimony and observations will be helpful to

our evaluation of the role of small business in the health care system.

Linda Montgomery, who is from Council Grove, KS, is a wife, a mother, and a health professional. Mrs. Montgomery was diagnosed last year with bone cancer. Her physician has recommended that a bone marrow transplant may hold the best hope of survival for her. However, her insurance does not cover this type of transplant.

I have asked Linda to testify today because I believe that we must as part of comprehensive health care reform address the very difficult issue of coverage for experimental therapies. These therapies may hold the only hope of survival for individuals, but may also significantly add to the health care costs shouldered by everyone.

I do not know the answer to this dilemma of balancing health care costs with access to potentially life-saving remedies; but the questions posed by very costly treatments made possible by the rapid advances we have made over the past several decades in medicine and technology are important for everyone to consider. Those who are on the cutting edge, of course, lead the way in answering many questions which these new advances pose.

But I do know that our current coverage policies vary widely and are often neither rational nor fair.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Wofford.

OPENING STATEMENT OF SENATOR WOFFORD

Senator WOFFORD. Mr. Chairman, it is good and important that the experiences of our witnesses are being voiced at this congressional hearing.

We had an extraordinary experience yesterday with the First Lady, analyzing the whole problem and presenting in an amazingly sweeping and detailed fashion the President's proposals. But you today, our witnesses, I know are going to match her. You are the other half that we need to hear, because the problems that you have faced have been voiced around the country for a long time, but have somehow still not been heard by the Nation—or, they have been voiced and not acted upon. So it is very good that the time has finally come—a time I have been pushing for since a campaign 2 years ago in which I brought this issue forward in Pennsylvania—the time when our Nation's political leadership is recognizing that the health care status quo cannot continue and that we have got to do something to change it.

That system is broken for too many people. In my home State of Pennsylvania, people are suffering from a lack of security, most of the people, although we have a relatively high proportion of people covered with insurance.

Like our witnesses today, Pennsylvania families are being denied coverage or charged astronomical premiums because a child has asthma or another pre-existing condition. Individuals who are underinsured are becoming bankrupt by high out-of-pocket costs. And as you will hear from Joseph Roach, a Pennsylvania retiree, early retirees must worry about meeting their future health care needs as more and more employers are cutting back on promised benefits in order to cut costs.

And perhaps one group that is being hurt the most by the status quo is small business. Small business owners are being charged much higher premiums, up to 35 percent higher, than their larger counterparts, and their premiums continue to go up. Many small business owners who want to offer their employees coverage cannot afford to do so or are denied the opportunity because they happen to employ one person with poor health.

Small and large businesses are charged higher premiums to cover the costs of the uninsured because some of their counterparts refuse to offer their employees coverage.

So those are the problems that we are beginning to wrestle with, and we have got to win that match. And your facts and your personal experience are going to help us do so.

I am grateful to all of you for your time, which is the thing we have least of in this world.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Senator Durenberger, do you have a statement?

Senator DURENBERGER. No, Mr. Chairman. I am just pleased to be here.

The CHAIRMAN. Thank you.

The basic concept today is to try to take some very typical situations and measure them against what is before the Congress in the statement of principles of the President's program, and get people's reactions to that program and see how it would affect them and their lives and their future.

I would just mention that Senator Dodd wanted to be here and plans to try to be with us a little later for Tomaca Govan's testimony, but we'll include his statement in the record at this point.

[The prepared statement of Senator Dodd follows:]

PREPARED STATEMENT OF SENATOR DODD

Mr. Chairman, I want to thank you for holding this hearing today to put a human face on what will be a very long and detailed debate on health care reform.

Inportance of individual stories

In all of our discussions of health maintenance organizations and preferred provider networks, of pre-existing conditions and employer mandates, of numbers and systems and percentages, I fear that we may lose sight of what should be a central focus of the health care debate—the human faces that comprise the uninsured and human stories that mark our health care crisis.

It is these stories that have made health care reform one of the Nation's top priorities. We must keep them foremost in mind as we debate the issues in the coming months.

Nicole Iannuzzi

I went to the floor several weeks ago to share the story of Nicole Iannuzzi—a girl from Trumbull, CT—to put a human face on the problem of children and health security. Nicole found out that she had no coverage shortly after her doctors diagnosed her with a spinal cord tumor. Her father, who is a self-insured businessman had just switched policies when she was diagnosed. The new company

said that it would not cover her because her problem was "pre-existing."

While Nicole is thankfully recovering from her illness, she and her family live with a great deal of uncertainty about the future. Because of Nicole's illness, the Iannuzzi's face a debt of close to $200,000. They cannot obtain affordable insurance for Nicole, not even to cover a routine exam. The best they can buy is a policy that costs $937 per month. And this policy—as incredibly expensive as it is—will not cover any problems related to Nicole's back.

Nicole's story is terrible, but not unusual. It illustrates why we must tackle the problems of the health care system and enact meaningful health care reform legislation. For we know that right now in this country, there are 12 million children without the protection of health insurance. And we know that 2 million people lose insurance each month.

The individuals who lack coverage may not understand the complexities of our health care delivery system. But what they do understand is the pain of an illness left untreated, the anxiety of an uncertain future, and the problem of facing huge, mounting medical bills, without much hope of paying them.

Connecticut witness

One of our witnesses this morning is Tomaca [toe-may-sha] Govan of Hartford, CT, who—because she has her own business—cannot obtain affordable insurance for her family. I look forward to hearing from her and from our other panelists, and hope we are on our way to eliminating the problems that have brought them before us this morning.

The CHAIRMAN. Before we begin I have a statement from Senator Mikulski.

[The prepared statement of Senator Mikulski follows:]

PREPARED STATEMENT OF SENATOR MIKULSKI

Mr. Chairman, yesterday we witnessed an extraordinary event. We had the opportunity to hear from the first lady of the United States who has become the Nation's expert and the President number one advocate for health care reform. What impressed me the most—is that she and the President have taken the ordinary stories of people around the country and translated them into the most significant public policy initiative in three decades!

It was an exciting and historic day. Only the third time in our Nation's history that a first lady has testified before Congress. But only the first time, a first lady has testified on a President's major domestic policy priority.

Today we are going to hear from our witnesses some of the stories the President and Mrs. Clinton have heard over the last year and a half. Sad and difficult stories about not having health care when you get sick. About losing health care when you get old. About having a sick child and not being able to afford to go to the doctor or buy the medicine to make him well.

We have all heard similar stories from citizens in our States—but it is important not to lose the real face of health care reform.

We all get caught up in the detail; in the structure; in the complexity. And we must produce legislation. But let's not forget for a

minute why we are here: to fix a system that is broken and doesn't work for the majority of our citizens. That's why today's hearing is so important. So that we keep our focus on the all too ordinary stories of people like our witnesses today.

I've set up a health care hotline for my Maryland constituents. I've asked my constituents to tell me their prescription for what ails health care. But as people leave their prescriptions, they also tell me their stories.

A woman from Hagerstown, MD called my office to tell me that she is spending more on prescription drugs than she is on her utilities. She told me about her friends who are spending as much for health care as they are on their rent.

A couple from Laurel, MD called my office to tell me their story. Don's company closed. Kathy had cancer and her treatments had been covered under her husband's policy until they lost their insurance when the business closed. She had $20,000 surgery without insurance and numerous other bills have piled up. They have lost everything. Kathy said they were reaping the benefits of the American Dream, but now their dream is gone and they'll have to work the rest of their lives to pay off the medical bills. People never think it can happen to them.

Our witnesses today will tell us stories like these and worse.

This is not the America we have known much less aspire to. People who play by the rules—work hard, pay their taxes, serve their country when called upon—end up without life or liberty or a chance at happiness because of a medical emergency.

If we don't reform this system, if we don't help to solve this problem, if we can't figure out how to make this system work better, we will have failed more than this task, we will have failed our country in a time of great need.

We have our work cut out for us. Before this plan was announced, I decided on a set of principles to use to guide my deliberations on this subject. I am pleased that it tackles the major issues: access, affordability, controlling costs, choice of plans and doctors, quality, eliminating the hassle factor and rewarding people who play by the rules.

I would like to thank the witnesses who have come here from all around the country to tell us their difficult and personal stories.

Thank you, Mr. Chairman.

The CHAIRMAN. Our first panel is composed of individuals who know first-hand what it is like to lack health security. Kathy Wojnar from Belchertown, MA lost her health insurance when she lost her job. She needs that health insurance because of a heart condition. I know her testimony will put this discussion about health reform in the proper context.

Joseph Roach, from Ambler, PA, is one of millions of early retirees whose company cut back on benefits.

We also have with us Linda Montgomery, from Council Grove, KS, who will share with us her personal fight against bone cancer and her struggle to find insurance to pay for her treatment.

Ms. Wojnar, thank you very much for joining us today. We look forward to hearing your story.

STATEMENTS OF KATHY WOJNAR, FORMER BUSINESS MANAGER, BELCHERTOWN, MA; JOSEPH P. ROACH, RETIRED BUSINESSMAN AND REALTOR, AMBLER, PA; AND LINDA MONTGOMERY, WIFE, MOTHER, RETIRED NURSE, COUNCIL GROVE, KS

Ms. WOJNAR. My name is Kathy Wojnar, and I currently reside in Belchertown, MA. I am a 37-year-old widow with heart disease. I was diagnosed with coronary artery disease when I was 34 years old and underwent a procedure called an arthrectomy to remove the blockage.

Initially, the procedure was thought to be a success. However, that evening, I suffered the first of three heart attacks. It was determined that during the arthrectomy, the physician tore my artery with the lead wire.

I underwent several angioplasties to open this artery, but it closed each time, causing two additional heart attacks. Fortunately, there was minimal damage done to the heart. However, even after laser surgery that was performed at Cedars-Sinai Hospital in Los Angeles, the artery still remains closed. There is no procedure at this time that will keep this artery open, and I was informed by my former physician in California that bypass surgery would provide little or no help to my situation. I take several medications per day, follow a strict diet and exercise program, and live a restricted lifestyle.

Up until April of this year, I was employed at Lambert Bridge Winery in California as a general manager. Through this company, I was provided with a good health insurance plan. We were a small company with under 20 employees. The winery owner lost a major lawsuit in 1991, and we were therefore forced to close the operation in December of 1992. I continued working until April of 1993. At that time, I lost my health insurance policy, and I am currently uninsured and uninsurable.

While we were still covered, and after my stay in the hospital, the insurance company raised our rates 60 percent. In order to combat some of the cost, I was forced to raise the deductible for all employees from $250 per year to $500 per year. It was a difficult decision to make and to implement, as I felt responsible since it was my disease that caused this increase, and now everyone had to pay for it. Intellectually, I knew that having heart disease was not my fault, but I still felt extremely guilty.

After losing the lawsuit, the winery was put up for sale. I knew that I would probably be losing my job and therefore would be facing a major problem in regard to health insurance. I spoke to our broker and was informed that because we had under 20 employees, the insurance company did not have to offer COBRA, but were required to offer a conversion plan. He also stated that if I did not take this conversion, I would be virtually uninsurable.

I checked with the insurance company and was informed that for myself, the conversion would be approximately $850 per month and that the insurance would not be the same coverage. There would be no prescription drug insurance, not dental, etc. It would be your basic major medical insurance. I felt that I should still take this conversion, though, when the time came as I had no other alternative.

Just before I left the winery, I again contacted our insurance company. I was informed that because the business had closed, they did not have to offer the conversion; therefore, they were canceling my insurance. I have been without insurance since that time and pay approximately $400 a month for prescription drugs.

After the winery closed, I decided to sell my house, which I did at a loss, and moved back to my home State of Massachusetts. My family is there, and with my husband deceased, my health situation and lack of employment, I thought it best to move back home.

Just prior to leaving California, my cardiologist also moved. I was given copies of my records and sent on my way. So now I was not only without health insurance, but without a physician as well. This left me feeling frightened and alone. My former physician did provide me with prescriptions that would last a few months, but I was instructed to find a cardiologist as soon as possible.

I began phoning cardiologists in western Massachusetts to make an appointment. When I spoke to the office staff, I was asked if I had health insurance. When I answered no, I was told that they were not taking new patients. When I mentioned that I would pay for my own bills, the best one office would do was to put me on a waiting list. I was also told by another office that I needed to find a primary care physician who could refer me to them. I told this office that I was a cardiac patient, I had my records, and I did not want to incur the expense of seeing another physician. They would still not see me.

During the humidity of the summer, I was having trouble breathing, and when I asked a nurse at one of these offices if this was normal for cardiac patients, she responded that she did not know, and that I should go to the emergency room. I felt the situation was not serious enough to incur the expense of an emergency room visit, so I did not go. I was simply looking for some reassurances from her.

I finally made an appointment with an internist that my sister used to work for. They did not want to see me, either, but when I mentioned that my sister used to work for this doctor, they spoke to him, and he accepted me. I saw him on September 17th. He was very concerned that I had been without medical care for so long, sent me to a lab for blood work, and got me an appointment with a cardiologist.

This cardiologist is not aware that I do not have health insurance, so this may be my first and last appointment with him.

The question of insurance also plays a big part in my job search. I need to and want to work. I spend many hours each week looking for employment. I am afraid, however, that once I am hired, my health situation will become an issue. So far, I have not mentioned this during any of my interviews and will only mention it in regard to health insurance. I was told by a health insurance broker that the only way I could possibly get insurance with this pre-existing condition was to become employed by a large corporation and hopefully, the insurance application would just get pushed through.

Recently, I was offered a job at a much lower pay rate than I was making in California. I would have considered taking the position if there were health insurance benefits, but there were not. I was recently up for a position in a much larger company, for the same

low salary, but there were health benefits. If it had been offered to me, I would have accepted this position. Again, I may not have been accepted by their health care provider, but it would have been worth a try.

The thought of spending the rest of my life without health insurance is a frightening notion. If I need to have any tests done other than blood work, I cannot afford it. If I must go into the hospital, it will wipe out what little savings I have. Once that is gone, then the State will have to pay for me. I do not want to be dependent on anyone else for my health care.

I am fortunate to have a small income besides unemployment benefits, so I can afford my $400 per month in prescription drugs. But for the first time this month, I will need to dip into my savings to pay for the doctor visits and lab work. There are also times when money is so short that I am not able to take these drugs as often as prescribed.

It is terrifying enough to live with a life-threatening disease, but to have this disease and no insurance makes it almost unbearable. In the past 2-1/2 years, I have lost my health, my husband, my job, and my health insurance. I struggle each day to start a new life for myself and to fight off the depression that keeps trying to sweep over me. If we do not have some kind of health care reform in this country, I may never be able to obtain health insurance again because of this pre-existing condition.

I am in favor of President Clinton's health care reform plan, and I only hope that the Government and the American people will realize how serious a situation this is for millions of people in this country. I not only live in fear that I am going to have another heart attack, but that this time I will be having a heart attack without insurance.

At least now, however, I do have two things to be thankful for. The first is I have finally found a physician who will at least prescribe my medications for me. The second is the health care reform plan introduced by President Clinton last week. For the first time, there appears to be some hope for people like me.

Thank you all for the opportunity to share my story.

[The prepared statement of Kathy Wojnar follows:]

PREPARED STATEMENT OF KATHY WOJNAR

My name is Kathy Wojnar and I currently reside in Belchertown, MA. I am a 37-year-old widow with heart disease. I was diagnosed with coronary artery disease when I was 34 years old, and underwent a procedure called an artherectomy to remove the blockage. Initially the procedure was thought to be a success. However, that evening I suffered the first of three heart attacks. It was determined that during the artherectomy the physician tore my artery with the lead wire. I underwent several angioplasties to open this artery, but it closed each time, causing two additional heart attacks. Fortunately there was minimal damage done to the heart. However, even after laser surgery was performed at Cedar-Sinai Hospital in Los Angeles, the artery still remains closed. There is no procedure at this time that will keep this artery open, and I was informed by my former physician in California that bypass surgery would provide little or no help to my situation. I take several medications per day, follow a strict diet and exercise program, and live a restricted lifestyle.

Up until April of this year, I was employed at Lambert Bridge winery in California as a General Manager. Through this company, I was provided with a good health insurance plan. We were a small company with under 20 employees. The winery owner lost a major lawsuit in 1991, and we were therefore forced to close the operation in December of 1992. I continued working until April of 1993. At that

time, I lost my health insurance policy, and I am currently uninsured and uninsurable.

While we were still covered, and after my stay in the hospital, the insurance company raised our rates 60%. In order to combat some of the cost, I was forced to raise the deductible for all employees from $250 per year to $500 per year. It was a difficult decision to make and to implement. I felt responsible, since it was my disease that caused this increase, and now everyone had to pay for it. Intellectually, I knew that having heart disease was not my fault, but I still felt extremely guilty.

After losing the lawsuit, the winery was put up for sale. I knew that I would probably be losing my job and would therefore be facing a major problem in regard to health insurance. I spoke to our broker, and was informed that because we had under 20 employees, the insurance company did not have to offer COBRA, but they were required to offer a conversion plan. He also stated that if I did not take this conversion, I would be virtually uninsurable. I checked with the insurance company and was informed that, for myself, the conversion would be approximately $850 per month, and the coverage would not be the same as under Lambert Bridge's company coverage. There would be no prescription drug insurance, no dental—it would be your basic major medical insurance. I felt that I should still take it, though, when the time came, as I had no alternative.

Just before I left the winery, I again contacted our insurance company. I was informed that because the business had closed, the insurance company did not have to offer a conversion. Therefore, they were canceling my insurance. I have been without insurance since that time and pay approximately $400 per month for prescription drugs.

After the winery closed, I had decided to sell my house, which I did at a loss, and moved back to my home state of Massachusetts. My family is there, and with my husband deceased, my health situation, and my lack of employment, I thought it best to move back home. Just before I left California, my cardiologist moved to Eureka, CA. I was given copies of my records and sent on my way. So now I was not only without health insurance but without a physician as well. This left me feeling frightened and alone. My former physician provided me with prescriptions that would last a few months, but I was instructed to find a cardiologist as soon as possible.

I began phoning cardiologists in western Massachusetts to make an appointment. When I spoke to the office staff, I was asked if I had health insurance. When I answered no, I was told that they were not taking new patients. When I mentioned that I would pay for my own bills, the best one office would do was to put me on a waiting list. I was also told by another office that I needed to find a primary care physician who could refer me to them. I told this office that I was a cardiac patient, had my records, and I did not want to incur the expense of seeing another physician. They still would not see me. During the humidity of the summer, I was having trouble breathing and when I asked a nurse at one of these offices if this was normal, she responded that she did not know and maybe I should go to the emergency room. I felt the situation was not serious enough to incur the expense of an emergency room visit, so I did not go. I was simply looking for some reassurances from her.

I finally made an appointment with an internist that my sister used to work for. They did not want to see me either, but when I mentioned that my sister used to work for this doctor, they spoke to him and he accepted me. I saw him on September 17. He was very concerned that I had been without medical care for so long, sent me to a lab for blood work, and got me an appointment with a cardiologist. This cardiologist is not aware that I do not have health insurance, so this may be my first and last appointment with him. The question of insurance is also a big part of my job search. I need to and want to work—I spend many hours each week looking for employment. I am afraid, however, that once I am hired, my health situation will become an issue. So far, I have not mentioned this during any of my interviews, and will only mention it in regards to health insurance. I was told by a health insurance broker that the only way I could possibly get insurance coverage with this preexisting condition was to become employed by a large corporation, and hopefully the insurance application would just get pushed through.

Recently I was offered a job at a much lower salary than I was making in California. I would have considered taking the position if there were health insurance benefits, but there were none. I was recently up for a position in a much larger company, for the same low salary, but it would have included health benefits. If the position had been offered to me, I would have accepted it. Again, I may not have been accepted by their health care provider but it would have been worth a try. The thought of spending the rest of my life without health insurance is a frightening notion.

If I need to have any tests done, other than blood work, I cannot afford it. If I had to go into the hospital, it would wipe out what little savings I have. Once that's gone, then the State will have to pay for me. I do not want to be dependent on anyone else for my health care. I am fortunate to have a small income besides my unemployment benefits, so I can afford my $400 per month in prescription drugs, but this month, for the first time, I will need to dip into my savings to pay for the doctor visits and lab work. There are also times when money is so short that I am not able to take my medication as often as prescribed.

It is terrifying enough to live with a life-threatening disease, but to have this disease and no insurance to pay for the necessary care makes it almost unbearable. In the past two-and-one-half years, I have lost my health, my husband, my job, and my health insurance. I struggle each day to start a new life for myself and to fight off the depression that keeps trying to sweep over me. If we do not have some kind of health care reform in this country, I may never be able to obtain health insurance again because of this pre-existing condition.

I am in favor of President Clinton's health care reform plan, and only hope that the government and the American people will realize how serious a situation this is for millions of people in this country. I live in fear not only that I am going to have another heart attack, but that this time I will be having a heart attack without insurance. At least now, however, I do have two things I can be thankful for. The first is that I have finally found a physician who will at least prescribe medications for me. The second is the health care reform plan introduced by President Clinton last week. For the first time there appears to be some hope for people like me.

The CHAIRMAN. Thank you. I think we'll hear from the whole panel and then come back to questions.

Mr. Roach.

Mr. ROACH. Chairman Kennedy, Senator Kassebaum, Senator Wofford, and other members of the committee, my name is Joe Roach, and I live in Ambler, PA. I would like to thank you for the opportunity to testify today about the need for health care reform for retired persons who are not yet eligible for Medicare benefits.

I worked for almost 40 years for a major computer manufacturer in a variety of senior management positions. Two years ago, I took an early retirement package from my company at age 59.

Health insurance is very important to me and my wife, who depends on my coverage. I am a diabetic, diagnosed about 15 years ago. I also become insulin-dependent about 5 years ago. Also about 5 years ago, I was operated on for cancer. Fortunately, up until now, there has been no recurrence.

Last year, I was diagnosed with heart disease and had an angioplasty which so far has been successful.

With these pre-existing conditions, obtaining health insurance for myself and my wife would be cost-prohibitive, if not impossible altogether.

As you know, many companies today are asking their employees to share in the costs of medical coverage. Some companies are trying to do away complete with retiree health benefits. With myself as an example, it is hard to imagine or even believe that a retiree who has contributed so many of his years to a life is today suffering reductions in benefits or being forced to pay the entire cost of the coverage.

Most early retirees like me were enticed to retire through additional benefits offered. These often related to payment of medical benefits. In my company, one of the major inducements was free or nominal cost medical benefits throughout retirement, for life. This was not a gratuitous offer. The company saved significant

payroll expenses by retiring many people at their peak earning years, myself included.

From the employee standpoint, there was a significant trade-off. In my company, early retirement meant serious reductions in pension payments during retirement—5 to 6 percent per year before age 65 for employees with less than 20 years of service, and before age 62 for employees with more than 20 years.

As an example, someone with 35 years of service retiring at age 65 would have his or her pension reduced by 35 percent in some plans and 42 percent in others. If you assume that someone's pension would be approximately 40 percent of his or her last 5 years' average salary, reduce that by 35 percent. The resulting pension would be only 26 percent, or roughly one-quarter, of the worker's average salary or wages for the 5 years before retirement.

Just to give you a couple of examples, if someone was making $20,000 average salary, their retirement would be $5,200 per year. At $30,000, that would be $7,800 per year. And someone who averaged $40,000 would have the magnificent sum of $10,400.

Pensions are computed considering service and compensation. An employee retiring at 55, as in my example, has given up 7 to 10 years' salary at his highest level of income. That employee has also accepted a reduced pension, because of a lower service multiplier, the 7 to 10 years that he gave up. He has also foregone higher average earnings for that period—anywhere from 7 to 10 years at his highest level.

Please keep in mind that the pension is further reduced by 5 or 6 percent for each year before age 65 per our company's plan.

In addition, an employee who intended to work until age 65 has also given up 20 percent of his Social Security benefits, having probably had to start receiving Social Security benefits at age 62 instead of age 65, because of his lower income.

I strongly feel that any contributions expected of early retirees under health care reform must take into account that they already have had to make significant sacrifices and should not be required to pay as much as other retirees who have not had to sacrifice.

As a specific example, my company has informed me and other retirees that because of increased medical costs and pressures on profits, that it is changing the medical benefits for all retirees, not just future retirees.

Effective in January 1996, both early and regular retirees will have to pay the entire cost of their coverage for medical benefits. Increasingly large portions will have to be paid in 1993, 1994, and 1995. The company projects that the cost for a retiree and spouse, both under age 65, under their program, will be $9,500 per year by 1996, which in many cases will consume the entire pension check and more, leaving nothing for other necessities. Worse still, many retirees may have to make the decision to give up coverage and risk total financial disaster from a serious illness or hospitalization.

It is important to note that for employed workers, these possibilities for retirement years are having a severe negative effect on morale in the workplace. Many employees feel they can no longer trust their employers. Low morale and increasing mistrust has to

mean long range reductions in our productivity as a Nation. This is extremely important in the competitive world market of today.

I and my fellow retirees are taking our company to court to stop this incredible breach of contract and violation of law. Whatever the outcome of our particular case, however, the problem of early retirees will endure. By definition, early retirees have no Social Security income. If they have a pension, a big portion of it has already been lost in the trade-off to retiree early. Finding employment is difficult.

Our former employers are unconscionably casting us adrift, just when we have increasing medical needs. Companies are placing the bottom line ahead of ethics, honesty, and human values.

Meeting the needs of early retirees is a vital part of national health care reform. I am very encouraged by what I have learned about how the President's Health Security Plan proposes to provide secure coverage for early retirees.

I also strongly believe that the immediate problem of retirees losing their employer-sponsored coverage must be addressed now. Senate Bill 1268 introduced this past summer by Senator Wofford would do a great deal to help early retirees by requiring employers to continue coverage during litigation.

I and my fellow retirees therefore urge you to support and promptly enact S. 1268 to provide this immediate protection to retirees whose companies are removing or significantly reducing their benefits.

Our needs must be addressed through comprehensive health care reform. I hope Congress will consider our needs and move swiftly to enact this bill.

Gentlemen, my appreciation for your attention and for your concern for the early retirees, as this critically needed legislation, comprehensive health care reform, moves through Congress.

Thank you.

[The prepared statement of Mr. Roach follows:]

PREPARED STATEMENT OF JOSEPH P. ROACH

Chairman Kennedy, Senator Kassebaum, Senator Wofford, and members of the Committee: My name is Joseph P. Roach and I live in Ambler, PA. Thank you for the opportunity to testify about the need for health care reform for retired persons who are not yet eligible for Medicare benefits.

I worked for almost 40 years for a major computer company in a variety of senior management positions. Two years ago, I took an early retirement package from my company at age 59.

Health insurance is very important to me and my wife, who depends on my coverage. I am a diabetic, diagnosed about 15 years ago. I become insulin-dependent about 5 years ago. Also about 5 years ago, I was operated on for cancer; fortunately, up to now there has been no recurrence. Last year, I was diagnosed with heart disease and had an angioplasty which so far has been successful.

With these pre-existing conditions, obtaining health insurance for myself and my wife would be cost-prohibitive, if not impossible altogether.

As you know, many companies today are asking their employees and retirees to share in the costs of medical coverage. Some companies are trying to do away completely with retiree health benefits. With myself as an example, it is hard to imagine or believe that a retiree who contributed many years of his life to a company is today suffering reductions in his benefits or being forced to pay the entire cost of coverage.

Most early retirees like me were enticed to retire with additional benefits. These often related to payment of medical benefits. In my company, one of the major inducements was free or nominal cost medical benefits throughout retirement, for life.

This was not a gratuity. The company saved significant payroll expenses by retiring many people at their peak earning years.

From the employee standpoint, there was a significant trade-off. In my company, early retirement meant serious reductions in pension payments during retirement—5 to 6 percent for each year before age 65 for employees with less than 20 years of service. As an example, someone with 35 years service retiring at age 55 would have his or her pension reduced by 35 percent in some plans, and 42 percent in others.

If you assume that someone's pension would be 40 percent of his or her last 5 years' average salary and reduce it by 35 percent, the resulting pension would be only 26 percent, one quarter, of the worker's average salary or wages before retirement.

Average Salary/Wages	Early Retire Pension
$20,000	$5,000
$30,000	$7,800
$40,000	$10,400

Pensions are computed considering service and compensation. An employee retiring early has given up 7 to 10 years' salary. That employee has also accepted a reduced pension, because of a lower service multiplier and foregone higher average earnings for 7 to 10 years. And keep in mind the pension is further reduced by 5 or 6 percent for each year before age 65.

In addition, an employee who intended to work until age 65 also has given up 20 percent of his or her Social Security benefits, having probably had to start receiving Social Security benefits at age 62 instead of age 65.

Any contributions expected of early retirees under health care reform must take into account that they already have had to make significant sacrifices and should not be required to pay as much as other retirees who have not.

My company has informed me and other early retirees that, because of increased medical costs and pressures on profits, it is changing the medical benefits for all retirees. Effective in January 1996, both early and regular retirees will have to pay the entire cost of their coverage for medical benefits. Increasingly large portions will have to be paid in 1993, 1994, and 1995. The company projects that the cost for a retiree and spouse both under age 65 will be $9500 per year by 1996, which in many cases will consume the entire pension check and more, leaving nothing for other necessities. Worse still, retirees may have to give up coverage and risk total financial disaster from a serious illness or hospitalization.

For employed workers, these possibilities for retirement years are having a severe negative effect on morale in the workplace. Employees feel they cannot trust their employers. LAw morale, and increasing mistrust, has to mean long-range reductions in our productivity as a nation.

I and my fellow retirees are taking the company to court, to stop this incredible breach of contract and violation of law. Whatever the outcome of our particular case, however, the problem of early retirees will endure. We have no Social Security income. If we have a pension, a big portion of it has been lost in the bargain to retire early. Finding employment is difficult. Our former employers are unconscionably casting us adrift, just when we have increasing medical needs. Companies are placing the bottom line ahead of ethics, honesty, and human values.

Meeting the needs of early retirees is a vital part of national health care reform. I am very encouraged by what [have learned about how the President's Health Security Plan proposes to provide secure coverage for early retirees. I also believe that the immediate problem of retirees losing their employer sponsored coverage must be addressed now. Senate Bill 1268, introduced this summer by Senator Wofford, would do a great deal to help early retirees, by requiring employers to continue coverage during litigation. I and my fellow retirees therefore urge you to support and promptly enact S. 1268 to provide this immediate protection for early retirees. Our needs must be addressed through comprehensive health care reform. I hope Congress will consider our needs and move swiftly to enact it.

Thank you for your attention and for your concern for early retirees as this critically needed legislation, comprehensive health care reform, moves through Congress.

The CHAIRMAN. Thank you very much.

Ms. Montgomery.

Ms. MONTGOMERY. Thank you, Mr. Chairman and Senators. I am very grateful for the opportunity to come today and speak before you, and I would like to thank you beforehand.

My name is Linda Montgomery. I currently have a social work degree, a degree in mental health, and I am a licensed mental health technician practicing at Stormont Vail Hospital in Topeka, KS, the largest medical center in northeast Kansas.

A year ago, I was diagnosed by my doctors with multiple myeloma, a form of bone cancer, also a diagnosis usually given to the elderly of a mean age between 65 and 75 years. It is rare for someone my age to have this affliction.

But this year, by my insurance company, I was given a death sentence when, through Federal legislation, they were allowed to refuse to treat me.

Following my diagnosis in the fall of 1992, my physician advised me to seek chemotherapy immediately. My own hospital was too busy to take me in for the initial outpatient procedures that I needed in order to start my chemotherapy, so my doctor then arranged for me to go to a neighboring hospital to get these outpatient procedures done.

While I was waiting for the procedure in the outpatient waiting room, I collapsed from hypercalcemia, a side effect of my condition at that time. As I became unconscious, I was admitted on an emergency basis to the neighboring hospital. This was how I became aware that while the insurance card that I carry looks like a Blue Cross and Blue Shield card, and all correspondence I receive comes from Blue Cross, what I really had was insurance coverage through a self-insured plan carried through Stormont Vail and administered by Blue Cross only.

Even though I was unconscious at the time and unable to give coherent instructions as to my needs, Blue Cross on my behalf later penalized me 25 percent of the normally covered expenses in addition to my regular deductible and my co-pay for my hospitalization. This I found out was just to be the beginning of the insurance and financial nightmare that continues to this day.

Conventional chemotherapy for me proved unsuccessful, and 6 months later I relapsed and had to be rehospitalized. This time, I was hospitalized in my own hospital.

During the time following the first and second hospitalizations, none of my medical bills were paid, including Stormont's own bills. Bill collectors from my own employer became more persistent than many of the others, trying to get money from a person. Twice, they insisted that I sign a payroll deduction form so that they could begin to try to receive payments on these bills, although I had no income.

I am still unable to work to this day. Blue Cross, on behalf of Stormont, then spent the rest of this time searching for evidence that my condition had pre-existed, so that from that point they would be unable to deny my claim entirely.

Also, while I was still hospitalized in April, the second hospitalization, I had applied for Social Security as soon as I was diagnosed, on the advice of doctors and hospital personnel. So I had applied, and I had received notice that I had been denied my claim

and was advised it was my right to reapply if I wanted to. I did so, and was denied a claim a second time.

Knowing this, I decided at that time that I would have to attempt to return to my job, and I did so. Social Security after the second denial told me that what I should do was continue to work; if I could not work in my current capacity on this gero-psychiatric unit, which is what I do in the nursing service, that I should seek a job as an office manager, a position for which I am not even trained.

So I filed an additional appeal at this time with the administrative law judge and was later sent a letter and told not to expect a hearing to be scheduled for at least 3 to 5 months, at which time I might want to seek legal counsel.

So at this point, being totally frustrated, I wrote a letter to seek aid from my Senators and have just recently in the last few weeks qualified for disability from Social Security.

Following this hospitalization in April, and with the aid of my physician, I was able to apply and also qualify for an experimental protocol that is being sponsored by the National Cancer Institute and the National Institute of Health. So I have begun this treatment, and after 6 months of facing death and bill collectors and their attorneys, Blue Cross finally came through and began to pay some of the bills of my claim.

I still have not been able to achieve a remission even on this investigational drug, but I have been able to maintain some control over my disease to this point. My doctor, however, advises that this is time-limited, since I am not in remission, and I have to be aware of that, and I would like to make you all aware, that my only real chances for a return to health would be to have what is now called a stem cell bone marrow transplant.

This procedure is not considered experimental in many cases and is also a recognized therapy for persons with cancer of the blood-forming organs, which is what I have. In checking with Blue Cross, they initially said that I was covered. I was grateful and went running back to my doctor to tell him the good news. They then checked further and called me the next day and said no, my plan wouldn't cover the procedure; it only covered certain cancers, and mine wasn't one of them. And it did not mention multiple myeloma at all in their contract, so it would not be covered in the future.

In 1991, before my diagnosis, after the loss of several jobs due to the economy—both my husband and I had lost about two jobs apiece—my husband and I decided to withdraw all of our retirement money and invest it in a small ice cream shop business as a hedge against future unemployment. We moved to a small town in Kansas, Council Grove, with a population of roughly 2,000, and began our business there. We purchased this business from the bankruptcy court, and while we have made great strides in this business, if we make any money in 1993, it will be our first profit. We have owned this company for 2 years.

At the same time, we employ between 20 and 25 employees in this community, which is roughly 2.5 percent of our population. And since I could no longer work and was refused disability, in an effort to maintain my home, I sold first my furniture, my valued and prized antiques, later my appliances—all to make my house

payments. Finally, in an effort to try to cover the unpaid medical bills and the 25 percent penalty that they gave me for my insurance, I had to sell my house, because I could no longer maintain the mortgage and was about to be foreclosed on.

Unfortunately, I hadn't owned the house long enough to have equity built up, but the foreclosure didn't cost me on my credit—the only benefit I think we received.

I now live in a secondhand mobile home. I was advised that I should apply for Social Security and seek SSI and a medical card from my county social and rehabilitative services office. SSI notified me, and with their regrets, told me that since I still maintained an IRA with slightly over $3,000 in it, that I did not qualify, and I was refused SSI assistance, and even if I had renewed this IRA and paid the taxes and the early removal penalty and paid these medical bills—some of them—that still, the store and its operating losses during the winter months was considered an asset, and I would not qualify.

Later, social and rehabilitation services, whom I contacted to see, as a disabled person, if I would be able to qualify for a medical card, told me that, yes, I could fill out an application; yes, I could try to apply for a medical card. They said that, yes, indeed, I was legally disabled, and because I did have this business, that there wasn't a thing they could do for me because it was a major asset; and that if I wanted to qualify for this medical card and get help, that I needed to divest myself of the business, my husband then becoming unemployed.

Also, the thing I found most difficult to deal with was they said it was unfortunate that they couldn't do anything for me; my only other alternative would be to seek a divorce because as an independent woman with no support, I would then qualify.

Now, I need to tell you at this point that the stresses of having to live with any catastrophic illness alone is enough to tax many marriages, possibly ending them. But when couples with the loss of career, the loss of my income, insurmountable medical bills, plus the emotional stresses I have personally of living with a body that I no longer recognize, being bald, loss of intimacy in my personal marital relationship, the loss of friends, a move to a different community, and no longer a social life because my health won't permit it—few marriages could stand these stresses, and I consider myself fortunate to be married at this time.

My husband, however, is a wonderful, caring, and very supportive man, and because of our Christian beliefs and our personal ethics, divorce is out of the question.

We also have to realize at this point that we have no other alternative and no way at all to pay for any treatments that I need. And now the bone marrow transplant seems to be totally out of the question.

Several people have come to me with documentation about how they may have the diagnosis that I have—there are few of us—but I have learned through phone calls, through my Senator's office, through support groups that there are other people like me out there. Some of them, after learning about my diagnosis, were able to get help; they sought that help through their State insurance commissioner. They got their insurance company then to cover

their bone marrow transplants. One of these cases, I learned later, was from my home town, and it involved Blue Cross. The lady was then permitted the bone marrow transplant; she died before she received it.

When I called the insurance commissioner's office at that point, they were very sympathetic to my plight and then explained to me that what I had was a Blue Cross administered plan; it was a self-insured group plan and was not under their jurisdiction as insurance commissioners, and in short, there wasn't a thing they could do to help me.

This was also confirmed later by the director of the risk management office in my own hospital, Stormont Vail, who at the time would not talk to me on the telephone but sent a secretary to tell me that, "If it wasn't written in our insurance contract, then we won't cover it—sue us."

This, I had not expected from the place where I had worked, and this was probably the hardest knock of all—the same hospital whose motto is: "Caring for generations."

Several friends and acquaintances who are physicians said there would be no problem with Medicare, and they would assist with my needing of treatment for this procedure. But then they were as shocked as I was in the beginning when I learned that even though I was a permanently disabled person, I did qualify for Social Security, but I cannot qualify for Medicare for 2 years, something you all are aware of. So for me, this is mostly likely going to be 1 year too late.

It seems at this point that I am at a dead end and little can be done to help me. But you as Senators are about to write a new chapter in health care, and you have the opportunity to see that others in the future won't fall between the cracks in the system the way I seem to have done so thoroughly.

I want you to know that as small business owners, my husband and I want very badly to offer health care to our employees; but under the current system, we just cannot.

When other business owners in town learned that I had this opportunity to come before you and speak, they asked if they could please add their voices to mine as I came before you, and tell you that they also want health insurance for their employees and to please try to get the point across to you. So I am here to carry that message that they consider the need for health care important, and they, as a very caring community, want too the health and safety of all their employees in these small businesses.

I don't know enough about the Clinton plan at this time. I did hear him speak, but as we all know, we need to know more in depth. What we hear in the media, I always take with a grain of salt, because a lot of it seems to be highly sensationalized. But I have had the opportunity to study Senator Kassebaum's proposal, and I would whole-heartedly support health care reform of that nature.

I with you all Godspeed. I hope you can do this expeditiously, get health care for American citizens. For me, the clock is running.

I thank you.

[The prepared statement of Ms. Montgomery follows:]

PREPARED STATEMENT OF LINDA MONTGOMERY

My name is Linda Montgomery. I have a BSW and a degree in mental health and work in the geriatric-psyc diagnostic unit of Stormont Vail Hospital in Topeka, KS, the largest medical center in north east Kansas. A year ago I was diagnosed, by my doctors, with multiple myeloma a form of bone cancer, but this year I was sentenced to death by my insurance company and the Federal legislation that allows companies to self insure.

Following my diagnosis in the fall of 1992 my physician advised that chemotherapy begin immediately. My hospital was too busy to do the initial procedures necessary so my doctor arranged for me to go to a neighboring hospital to have the procedures done on an out patient basis. While I was waiting for the procedure to be done I collapsed from hypercalcemia a side effect of my condition, became unconscious and was admitted on an emergency basis to this neighboring hospital. This was how I became aware that while the insurance card I carry looks like a Blue Cross card and all correspondence comes from Blue Cross what I really have is a self insured plan from Stormont Vail administered by Blue Cross. Even though I was unconscious and unable to give coherent instructions Blue Cross, on behalf of Stormont, penalized me 25% of the normally covered expenses in addition to my regular deductible and co-pay. This was just the beginning of an insurance and financial nightmare that continues to this day. Conventional chemotherapy proved unsuccessful and six months later I relapsed and had to be rehospitalized. During that entire time none of my medical bills were paid, including Stormont's own bills. Bill collectors from my own employer were more persistent than many of the others. Twice they insisted that I sign payroll deduction forms even though I was unable to work at that time. Blue cross, on behalf of Stormont spent the entire time searching for evidence that my condition had pre-existed my employment at Stormont so they could deny the entire claim. Also while I was still hospitalized, Social Security denied my disability claim for the second time, this time claiming that I was fit to return to my job as an office manager, a position I have never held and am untrained for. I filed an appeal with the administrative law judge and was told not to expect to have a hearing scheduled for at least 3 to 5 months, at which time I might want to seek legal counsel. With the aid of my Senators I have just recently qualified for disability but I have been informed that I won't qualify for medicare for another two years. Following my hospitalization I was, with the aid of my physician, able to begin a new experimental protocol, never used before in this area, sponsored by the National Cancer Institute. At this point, after six months of facing death and bill collectors and their attorneys, Blue Cross began to pay some of the bills. I was not able to achieve a remission on this investigational drug but I have been able to maintain some control over my disease to this point. My doctor advises that this is time limited however and my only real chance for life lies in my ability to receive a stem cell bone marrow transplant. This procedure is not considered experimental and is a recognized therapy for persons with cancer of the blood forming organs. In checking with Blue Cross they initially said that I was covered, then checked further and said that my plan covers the procedure for certain cancers and doesn't mention multiple myeloma and since it isn't mentioned it isn't covered.

In 1991, because of the loss of several jobs due to slow downs in the economy, my husband and I withdrew most of our retirement money and purchased a small ice cream shop in a town of 2,000 in central Kansas as a hedge against future unemployment. We purchased the business from the bankruptcy court and while we have made great strides, if we make any money in 1993 it will be our first profit. At the same time we employee between 20 and 25 employees which is roughly 2.5% of the towns total population. Once I could no longer work, and since I was refused disability we were forced to sell our furniture, antiques and appliances in an effort to make house payments. Finally, to pay my medical bills and keep our business we had to sell the house before we got behind in the mortgage and we now live in a used mobile home. I was advised that I should apply for SSI and seek a medical card from my county SRS office. SSI turned me down because there was still more that 3,000 dollars in my IRA and even if I removed it and payed medical bills they felt they would still have to deny me on the basis of the money we have in the bank to cover the stores operating losses during the winter months. SRS informed me that no matter how much money you owe on the business or how little money you make, it is still considered a major asset and so I must either get rid of the business or seek a divorce from my husband. The stresses of having to live with catastrophic illness alone is enough to end many marriages, but when coupled with loss of job, loss of income, insurmountable medical bills, and the emotional stressors, the loss of intimacy due to illness, and the loss of friends and social life few marriages can

over come this. Because our marriage is still strong and because of our personal ethics divorce is not an option so we have no way to pay for the treatment I need.

Several people have come to me with documentation of how when they found themselves with my diagnosis, they were able to, with the help of their State Insurance Commissioner, get their insurance company to cover the bone marrow transplant. One of these cases was even from my town and involved Blue Cross. When I called the Insurance Commissioners Office they were very sympathetic but explained that even though Blue Cross administered the plan, it was a self insured plan and was not under the jurisdiction of the Insurance Commissioners Office. In short, there was nothing they could do. Which was confirmed by the Director of Risk Management for Stormont Vail Hospital, who would not talk to me directly but had his secretary tell me that he said if it's not written in the plan sue us. Several friends and acquaintances who are physicians suggested that there would be no problem since medicare would assist in the payment for the procedure, but they were as shocked as I was to find that even though I was qualified for disability I could not receive medicare for another two years. Most likely at least one year too late.

It seems like I'm at a dead end and little can be done to help me at this point, but you as Senators are about to write a new chapter in health care and have the opportunity to see that others in the future won't fall between cracks of the system the way I have. I want you to know that we as small business owners want to offer health care to our employees. But under the current system we can't. When other business owner's in town heard I was getting this opportunity to speak, they ask me to add their voices to mine in telling you that many small businessmen care about their employees and want help to keep them safe and healthy. I don't know much about the Clinton plan, because what you hear in the media seems to be highly sensationalized but I have had the opportunity to study Senator Kassebaum's proposal and we would wholeheartedly support health care reform of that nature.

The CHAIRMAN. Thank you very much, Ms. Montgomery, and all of our panelists, for your very moving and timely comments and presentations. I think we're going to hear an awful lot during this debate about what we are spending here, what we are spending there, about costs, about deductibles, about co-pays, about co-insurance. So much of the debate and discussion is on those issues, and we all know they are important. But we have three Americans, our fellow citizens, who have worked their whole lives—worked their whole lives—and have basically fallen through the cracks of the system; the system has "gamed" them.

Taking care of our fellow citizens is going to involve costs and expenditures, but any one of the problems that they have could happen to any one of us. It could happen to any one of us up here; it has happened I know in terms of our colleagues in different ways. I have a son with cancer who has been lucky enough to survive. But it could happen to any one of us, and if we aren't able to recognize that the kinds of voices that we have heard here today are really the voices of all Americans, and if we get weighted down, as some would have us do, in being reluctant to at least try to deal with these—we may not get it right, but we sure as the devil ought to try to get it right. That, we must do.

Very briefly, because the stories speak for themselves, I'd like to ask Kathy Wojnar, as I understand, you would be prepared if you could get coverage to make a contribution; would you not?

Ms. WOJNAR. Oh, absolutely.

The CHAIRMAN. You're not just trying to get something for nothing.

Ms. WOJNAR. Oh, no, absolutely not. I think we should all pay for our health insurance, but we should be guaranteed the right to get it.

The CHAIRMAN. And you have some income, and you are certainly prepared to participate in the system, but the problem is you can't even get in the front door because you are denied virtually any kind of consideration, no matter how much you could pay.

Ms. WOJNAR. That's right.

The CHAIRMAN. Then we have the retirees. American citizens—and Mrs. Clinton was talking about young people paying a little bit more the other day—had better listen to Mr. Roach here. It's not going to be too many years, and they are going to be right where Mr. Roach is. Let's point out—16 percent of all employers dropped retiree coverage between 1991 and 1992; just dropped them. That's 16 percent.

We've got 32 million active workers who have been promised retirement coverage. They had better start listening to Mr. Roach. They had better start listening and look at what has happened with employers over the period of the last 2 years. They have been dropped like hot potatoes and just pushed out into the cold.

This will continue to happen unless we are going to try to respond to those like Mr. Roach, who have worked 40 years of their lives, and unless we are going to try to, as the administration's proposal does, provide 80 percent of the cost of the premium. If the company had been participating, they will pick up the 20 percent. You'd be willing to participate, would you not, Mr. Roach?

Mr. ROACH. Yes; my point being, however, Senator, that we have already given up or traded off a significant portion of our promised pensions for this early retirement and no-cost health benefit. To go into that same pool, my point is that even if the Government picks up that responsibility from the private sector that the Government has to consider the fact of early retirees who have already given up anywhere from 20 to 40 percent of their pensions.

The CHAIRMAN. Well, I think you are absolutely right. Over in the Finance Committee, Mrs. Clinton got heavy, heavy-duty criticism for that aspect of the program just about 3 hours ago, from those saying we can't afford to look after those people. The estimate, at least before our committee, was about $4.5 billion even under the program.

I think you make an excellent case in terms of the additional equity for the early retirees beyond the 80 percent, and you make a very, very strong argument on that. But we're finding out that even this part of it has been criticized.

Your story is just so moving. We just don't quantify the kinds of anxieties that you described and which anybody can understand.

Mr. ROACH. Senator, hopefully, I was only describing that which is a condition for many, many people, not for myself. Many people are at a much lower income than I am able to attain through my own pension, and in many cases, these medical costs are going to exceed their pensions.

The CHAIRMAN. I think you said it well. I think the witnesses understand that we can be criticized by others saying that we can find three people in the country who have tough problems, but what all of you have commented on is the kinds of situations that are affecting millions of our fellow citizens.

Finally, Ms. Montgomery, your statement and comments, as I think every member of the committee understood, were brought to

our attention and national attention by Senator Kassebaum, in directly asking Mrs. Clinton about it yesterday in our committee hearing. So she has been a very effective advocate for you, and I am certainly hopeful that we can find the wisdom to be able to relieve you of the kinds of heavy anxieties that you are feeling with regard to the health aspects of it. It is just an absolutely horrendous situation, and you are an inspiring figure to be able to talk about it.

Ms. MONTGOMERY. You are very kind, Senator, and I do thank you for that. My purpose in being here, though, wasn't just to seek help and a sympathetic viewpoint for my own welfare. If I have a limited time on this earth, I have decided that I want to make a point of making sure that no other citizen in the future ever has to fall between the cracks as I did, and that health care should be a right in a country like this, not a privilege, and it has been left to the privileged citizens. And I am sorry to say that, but that's what we're coming down to. It is getting harder and more difficult than it is easier, and I am very grateful to finally see health care reform come to the fore during an administration. I think it is high time, and I know many of you feel that way, and I am grateful to see it happen and happy to participate in any way I can.

The CHAIRMAN. Well, you are absolutely right. Every member of the Congress has it—and I won't get into my little comments about those who are going to oppose it; I just hope they won't continue to take advantage of it themselves.

Ms. MONTGOMERY. And you can be aware that I am not necessarily the exception.

The CHAIRMAN. Thank you very much.

Senator Kassebaum.

Senator KASSEBAUM. Thank you, Mr. Chairman.

I would just like to observe that all three of you do represent many voices, and some in more special ways perhaps than others; also, all three represent enormous costs in the health care system one way or another. I think that is the dilemma as we try honestly to look at a situation where obviously there is great compassion for the individual and balance that concern with society's responsibility.

It isn't easy when we are trying to write legislation to do that in ways that can take everything into account. Mr. Roach, I think in your situation as an early retiree, this is an issue, because to a certain extent, the President's plan really moves the Medicare kick-in point from age 65 to age 55. The estimated cost of $4 billion, I would suggest, is quite low. It is going to be far greater. It doesn't mean that there isn't great concern for those who are being laid off and who have been encouraged to take early retirement and for those who see what they thought was going to be a lifetime of security just evaporate.

That's what, in another way, we are struggling with as I mentioned in introducing Linda Montgomery—the high cost of new technology and how do we meet it. Also, her testimony indicates the whole kind of web of the system that everybody can get caught in and, as you said, fall through the cracks.

I would like to ask Mrs. Montgomery first, why did your physician recommend that you receive a bone marrow transplant, and

is this something that you could get through the National Cancer Institute or a National Institutes of Health-sponsored trial in any way? Was this something that was explored?

Ms. MONTGOMERY. We haven't had a lot of time, really, to communicate. I have a wonderful doctor, Dr. Stanley Vogel, a wonderful oncologist, who also studies heavily all aspects of research and does belong to the Southwest Oncology Research Unit, which is a subsidized research organization. It was through that study, which is ongoing, that he had information about the Topotecan investigational drug that he is now administering to me, which is an i.v. therapy process.

Through reading the research, I had read and heard that bone marrow transplantation of the stem cell nature, where these cells harvest from my own body, would be an opportunity for me.

I asked my doctor about it. His eyebrows went up, and he got bright-eyed, and he said, "Do you really think your insurance could help you with that?" And with that, I had my first idea that, yes, this was the thing I needed to pursue.

As we talked, I found out that, yes, this was probably the best chance I had at not only protracted remission, but also the resumption of a healthy lifestyle where I might even be able to work once more.

As far as the NCI and the National Institutes of Health, I have to fall to my doctor for that, because as a study of research, he is the one who led me into this new investigational therapy that I am on. The process of applying for and meeting the criteria necessary to participate in such a study is rather lengthy and somewhat difficult, and you also have to have a connection through certain study groups. The doctor who is studying the Topotecan that I am taking now, his major research is seated, I think, in Columbus, OH, and it is through telephone and fax machines that most of my case work gets carried on.

So as far as the bone marrow transplantation, my doctor would have to pursue that for me; I would then take application and see if, health-wise, physically, I could meet all of the criteria necessary to qualify as a study aspect in an ongoing research program. If I qualify, then I might possibly receive one. No, the topic has not been broached at this time.

Senator KASSEBAUM. Have they given you any estimated cost for a bone marrow transplant for multiple myeloma?

Ms. MONTGOMERY. Dr. Vogel is a very conservative man, but I don't think he was conservative enough when he told me approximately $100,000. I have talked to many people since, and I estimate probably closer to $130,000 to $150,000. The costs vary in different institutions; I am not sure exactly why, but I know costs vary in different parts of the United States. So I sort of reserve the $150,000 amount in my head just to try to cover everything.

Also, you need to know that I am not pursuing a "gift" of a bone marrow transplant, even though I would happily participate in a study. When it appeared as though I was going to die rather quickly, I was happy to volunteer what I had to this study, because if I could do nothing more useful with my life than basically leave a legacy that might help another person, if that's all I had to offer, I was going to do it. If I could once again qualify for a study of that

nature, I would, but I am not even asking that for free. I would happily contribute to some portion of that myself, with whatever funding I could either raise or earn or as I continue to liquidate my personal holdings—but I'm afraid I'm getting down to the nitty-gritty at this point and don't have a whole lot left. But I do still have that precious IRA that I have hung onto until more medical bills need to be paid. Any of those things, I am willing to contribute toward expenses. So, no, I'm not asking for a gift nor a free lunch, and I don't think that anyone here on this particular panel is wanting that, either.

Senator KASSEBAUM. Mr. Roach, yes?

Mr. ROACH. If I could come back to one point, Senator, the overall health care reform that is being discussed, and what the President is proposing, will probably go through a long period of discussion and then a transition period. In the meantime, there are a number of companies that are unilaterally discontinuing, reducing, cutting plans. I think there is a stopgap that is needed in the meantime, and I think Senator Wofford's plan is an excellent one that would help stop that. If we don't, companies are going to start jumping on this thing like it's a rolling freight train, and before you know it, everyone in the country is going to be removed from medical benefits if they have been retired.

It is unconscionable. Something has to be done, and I think the Senator's plan is the answer. We would really appreciate any of your help in getting that plan pushed through Congress as fast as possible.

Thank you, Senator, for your help.

Senator WOFFORD. Thank you.

Ms. MONTGOMERY. If I might inject something, too, with Mr. Roach, Senator Wofford's plan also has something to offer for people who now are finding themselves in the unique position of being forced into early retirement; if you can make the criteria and then meet that sliding age, then it's also something, because I am finding as a disabled person who is probably no longer able to work, I qualify for many things under Social Security until they find out my age, and then all of those things go back out the window. So that is going to be very important as time goes on.

The CHAIRMAN. Linda, the interesting point is that even if you go to NIH, someone is paying for it. I mean, this is a game. Someone has got to spend a lot of time to see if you can get into one of those studies.

My son had osteosarcoma when he was 12 years old, and he was in a 2-year program, but after about 8 months, the experiment ended because they had sufficient information to make a judgment that it was positive. From that point on, it was $2,800 a treatment every 3 weeks for 3 days. And I remember going out into the waiting room and hearing parents say, because their child had about a 15 percent of living without this treatment, "What kind of chance does my child have if we can only pay for 3 or 4 months?" because they had finished the experiment at NIH, and the insurance companies hadn't picked it up. And it took years before the insurance companies would pick that up. The last thing they want to do is put something else in there that is going to slow down their profits.

I don't know how many times we have to keep hearing this story. My time has expired, and I exercise the prerogative of the chair, which I will not do again on this, but I couldn't help commenting.

Unfortunately, I must chair another hearing on a nomination for the administration, so Senator Wofford will chair the rest of the hearing. But I want to thank all of you very much, and I hope you'll take a look at the President's plan, and I hope you'll take an interest in it and hold our feet to the fire. You know, we may not always have it just right, and I hope you'll really take an interest and keep after all of us on it and make sure we do you justice.

Senator Wofford.

Senator WOFFORD [presiding.] Thank you, Mr. Roach, for your pitch for the stopgap bill. I hope my colleagues on this committee, in the same bipartisan fashion that we have looked at so many things so well in this committee in my brief experience here, once we have received the President's plan and have held these first basic hearings on it, will come together and look at that stopgap measure, because it would put real pressure on companies to keep plans in place while we move forward toward universal health insurance and while their canceling of benefits if being challenged in court.

Mr. ROACH. That's very important.

Senator WOFFORD. And I assure you that my colleagues and I will be looking at that soon.

As I listen to you, I think first: There, but for the grace of God, go I. And I remember my wife, in my own campaign for this job, being genuinely scared that because of a serious pre-existing condition she has, that if I lost the election and lost my job, that we would not have health insurance coverage, that it would be too costly or impossible to get—the same sorts of stories that we have just heard today—and that we wouldn't be able to pay the mortgage on our home very soon.

And then, aside from thinking personally, as I look at the people behind you, 30, 40 people who are concerned, listening to your stories, I think: There, but for the grace of God, go they, because if we don't move to universal health insurance security in this country, and if we don't find a way to stop the inflation in costs, the pressure on companies and institutions, on employers and on insurance companies, to do what you are reporting is going to just mount. And we have got to stop it. That is why I appreciate the urgency you are giving to us today, because every month, every day, more and more employers are feeling the need of being pressed to take steps to cut costs and cut out benefits and coverage.

So I am very grateful for what you gave us.

I have been carrying my own health security card around—it doesn't entitle me to anything yet, and it is a little different style from the President's, but I yield to the President. It is time that each of us has a card that makes clear that we will have health security, health care, when we need it. And we have to find the way to achieve that, and working together, I believe we can.

Senator Jeffords.

Senator JEFFORDS. Thank you.

I don't want to prolong the testimony any longer, because you have made very passionate and emotional speeches. But I would

like to emphasize the situations that you are in. We had earlier hearings on retirees which brought to my mind the kinds of policies that we are enhancing with our situation. We are creating very unfortunate hiring practices now. One certainly is to let workers go early; hire only the young and healthy; don't hire workers over age 40, and certainly not above 50; don't provide good pension plans to entice workers to want to stay with you.

These are very serious, not only from the perspective of leaving people without health care, but it is a real downer on pension plans to have good pension plans. It is a downer to having defined benefit plans any longer, because they get too expensive.

As bad as the situation is in health care right now, the thought of having good health care and not having a good pension are two of the worst possibilities, and we are leading ourselves into both if we don't do something about good health care.

So I want to thank you all for your testimony. It has been very helpful to us to accentuate the difficulties this Nation is getting into with the present health care policy.

Thank you very much.

Senator WOFFORD. Senator Wellstone.

Senator WELLSTONE. Thank you, Mr. Chairman.

I just wanted to apologize—this is one of those days when there are conflicts. But I wanted to come down just to tell you I appreciate your being here, and I will get hold of the written testimony and read it carefully.

Thank you for taking the time to come. And I would quite agree with what I think all of my colleagues have said, which is that this is a very special and I think very important moment in the history of the country, and we just simply have to come through for people. We have to do well for people. And I think your testimony is sort of a jolt, and it reminds everyone of what these statistics all mean in human terms and why it is so important that we don't stalemate and that we come together and pass really good health care reform for people.

Thank you.

Senator WOFFORD. Senator Gregg.

Senator GREGG. Ms. Montgomery, I think your case is the one that I find most difficult to deal with, because it's the one that I don't believe the President's plan deals with effectively, and I believe that Senator Kassebaum has made this point, and when I was——

Senator KASSEBAUM. I would just add I don't think any plan does, really.

Senator GREGG. Right. We don't have a system that deals with this. In fact, I was going to point out that when I had my prior job, which was running the State of New Hampshire as Governor, we had this same problem consistently coming up, and what we had in New Hampshire was a contingency fund, where we used to find money from all sorts of accounts to try to help people out who were in your position. But that doesn't work, either.

You have certainly been extraordinarily eloquent in making your point, and I would hope that whatever we put together addresses this catastrophic illness situation that falls between the experimental and the accepted practice, which is the procedure you are

talking about. Experimental, still, we probably cannot come up with something that will effectively deal with the experimental issue, but we have got to come up with something that deals with this area. One way to do it, I think, is through a national catastrophic insurance, and somehow, we have to work this into the process. But you have certainly highlighted a very important gap that exists in our system, and I appreciate your doing that.

Ms. MONTGOMERY. Thank you very much for your kind words.

Senator GREGG. Mr. Roach, I guess I have a question for you. You made the decision to go into early retirement, and you thought you had a contract with your employer that was going to give you health insurance. Now, I presume you do have legal recourse that you are pursuing—in fact, I think you stated that you have a legal recourse; you think those rights were contractually agreed to, and——

Mr. ROACH. With the retirees of our company, Senator, there have been 11 different lawsuits filed, all in a class action suit, three by union organizations and eight by nonorganized groups.

Senator GREGG. So there is a legal recourse that you have there.

Mr. ROACH. Yes.

Senator GREGG. I guess my question is if the Federal Government is going to come in and take over this area, which is extraordinarily expensive—the $4.5 billion is a ridiculous estimate; I mean, it's a ridiculously low estimate—do you think there ought to be some quid pro quo? For example, should that benefit be a taxable event to you?

Mr. ROACH. To the employee receiving the benefit?

Senator GREGG. To you. You are going to be getting $4,000 to $9,000 in insurance, which is now not taxable, assuming you are getting it, which you are not, unfortunately, because of your legal situation, but if you do get it, if the Federal Government sets up a structure where there is no question but that you are going to get it, as your participation in the process, shouldn't that be taxable income to you?

Mr. ROACH. Well, if it wasn't taxable when it was supplied by the company, why should it be taxable if it is supplied by the Government?

Senator GREGG. Because it is a major benefit. It probably should be taxable from the company, too.

Mr. ROACH. Well, that would have to be something that would have to be thought about in a retroactive sense, and if it were, then it certainly would bring in revenue, which someone should reduce other taxes.

Senator GREGG. I guess I just wanted your reaction as to whether or not—you then feel the Government should come in and simply take on this $4,000 to $5,000 burden, or maybe as much as $9,000 if you're talking about family structure——

Mr. ROACH. No, no. Don't let me allow myself to be misunderstood, if I may; maybe I did a poor job of explaining it. None of us are asking for a free ride. I think if you start to do things as of today, for the future, you can look at that as future income, taxing rights and percentages, and go from there.

The program that I was addressing primarily was the fact of where companies are now taking things that have already been

paid for, if you will, by giving up large portions of pensions and that type of thing, and then unilaterally deciding that they are no longer going to pay it. That's different from just taking a future benefit and deciding whether or not to tax it.

Senator GREGG. OK. I guess my question went to a different subtlety, then; I missed the point you were making.

Mr. ROACH. I think so, but believe me, I have no problem with paying part of the bill, and I don't think most Americans today do. People in this country are a lot more intelligent than many people give them credit for. They are also realists who know the economic situation today. We know the problems with budgets in the Federal Government, the State Governments. And people are willing to sacrifice somewhat.

But everything is relative. People don't want to have something that they have paid a considerable amount of money for turned around and taken away from them by someone else in a unilateral fashion. The retirees who gave up 30 and 40 percent of their pensions don't feel that their benefits now should be taken away from them; they have paid for them.

If this were to go back several years, and that condition did not exist, and you asked me the same question, my immediate answer to you, sir, would be that I would be more than willing to pay a fair share.

Senator GREGG. Thank you.

Senator WOFFORD. Mrs. Clinton yesterday on that subject here, as I heard her and as I read the plan, said that in the normal case where there has been no agreement from the company, the employee would contribute 20 percent. It would be approximately a 20 percent contribution. In cases where the company had made the explicit promises in their contracts, they would pay that 20 percent so that the employers and employees would both be contributing, in the proposal she is making.

Mr. ROACH. Yes. I hope, Senator, that I have distinguished between something that is retroactive and something that is in the future. For example, a company has a right to change some of its policies. If it were to decide that in the future, it cannot afford to cover the same kinds of medical benefits that it has in the past, it has a right to change that and to request the employees to pay a portion.

What we are looking at here, though, is companies unilaterally making decisions that are retroactive; people who have been told something for 20, 30 years and have paid for it in lesser wages, paybacks, trade-offs of pensions and everything else are all of a sudden told: None of that counts.

That is my point, and I hope, sir, that I have made that point clearly.

Senator GREGG. I think we understand that, but the point you were just making, Senator, of course, goes to the fact that what is being proposed here, independent of Mr. Roach's point, which is separate from that, is basically a new entitlement of massive proportions, because what is being said here is that for people between 55 and 65, the Federal Government is going to come in and pick up a minimum—or, potentially 80 percent, not a minimum—poten-

tially 80 percent of the cost of their health care insurance, which translates into—it has to be a lot more than $4.5 billion.

So the question is if the Federal Government is going to come in and assert that type of a new entitlement, shouldn't that become a taxable event. That's my point.

Senator WOFFORD. We'll certainly have to look at all the numbers. But Mr. Roach was also testifying as to the trade-offs involved in early retirement. You give up a lot of things. You give up the income that you would have had, and on the other side of the ledger, you give up various pension benefits and the actual salary that you are foregoing. If you are able to get another job, then you pay the contribution for that.

The other side of the ledger is that companies, because of the increasingly growing burden of the retiree health benefits, are not able to employ new people, so we are obviously dealing with a complex question, and we'll have to do a cost analysis as we move down the road.

Mr. ROACH. Senator, there is another word that hasn't been mentioned here that I think is extremely important, and that is "portability." Because of the fact that so many of these things are happening, people do not have the same loyalty to a company that they had before. You've heard people today talk about 30, 40 years with a company. I don't think you'll see that anymore. People are moving from company to company whenever they can get a better deal. And that is going to require that all these benefits be considered portable.

Senator WOFFORD. We thank this panel very much. It is very important for us that as we look at all these proposals from the President and from other people, that we test them against real human experience, practical experience, the kind that you have given us today. And I hope we remember your stories as tests to put up against, including Linda Montgomery's test for us, to see whether the system we move toward deals effectively with you situation.

Thank you all very much. I hope we can keep in touch with you as we move forward.

Our second panel this afternoon is composed of small business owners and self-employed people who have struggled with benefit cutbacks and premiums that continue to rise with no end in sight.

Cyndy Adams is here from Derry, NH. She and her husband run a contracting firm. She will describe the bite taken out of their payroll by insurance costs after her small business was reclassified by their insurance provider.

Mike Braxmeyer is a grocery store owner in Atwood, KS, who will describe the difficult situation he encountered when the son of one of his long-time employees developed leukemia.

Finally, we'll hear from Tomaca Govan, who took a gamble on the American dream. She left her job to start her own business and found herself shut out of the insurance market.

We look forward to hearing from all three of you, and we'll hear from Cyndy Adams first.

STATEMENTS OF CYNDY ADAMS, SUBCONTRACTOR, DERRY, NH; MICHAEL BRAXMEYER, GROCER, ATWOOD, KS; AND TOMACA GOVAN, OWNER, SECRETARIAL/WORD PROCESSING BUSINESS, HARTFORD, CT

Ms. ADAMS. My husband and I own and operate a Sub-S corporation doing consulting and engineering in the field of land use planning in southern New Hampshire. As self-employed individuals, we belong to the Salem Contractors Association which, as a group, had contracted with Blue Cross and Blue Shield of New Hampshire many years ago for their health insurance. Until a few years ago, our premiums had been affordable, and our annual increases were moderate.

In April of 1991, the 72 member businesses included in our group plan were notified by Blue Cross and Blue Shield that they had split our group and rated the premiums by the age and sex of the subscriber. Our premium increased from $389 a month to $560 a month for a family plan with a $100 deductible. That was a 44 percent increase. Others received even more substantial increases.

This monthly payment was impossible for us to manage, so we opted for a $250 deductible with a 20 percent co-pay at $484 a month. Of the 72 participating businesses prior to this change, 16 immediately dropped insurance for themselves and their employees, and 35 were forced to increase their deductibles. Today, only 29 of those businesses still have coverage.

In 1992, we were notified that our premium would only increase from $484 per month to $508 per month. Others who entered new age brackets were not as lucky, and many again increased their deductibles or dropped coverage completely.

This year, we were notified that our premium was to increase from $508 a month to $670 a month for a $250 deductible, a 32 percent increase. We were forced to take a $1,000 per person deductible and still pay $489 a month. Given the fact that our only claims last year were for a couple of cold and flu-type ailments, and our 6-year-old son's physical and some necessary prescriptions, we feel quite certain that the 1994 increase will force us to drop our insurance completely.

Prior to the 1991 increase, our health insurance represented approximately 11 percent of our payroll. With the increase in premiums and based on a very hopeful projection of our payroll this year, that cost will now be a minimum of 21 percent of our payroll.

During the 12-month period ending last quarter, that cost will now be a minimum of 21 percent of our payroll. during the 12-month period ending last quarter, our monthly insurance premiums exceeded our monthly payroll tax deposits six times. The fact that we cannot deduct 100 percent of this cost is another disadvantage to the current system.

As a Sub-S corporation, we are required to report the cost of our annual health insurance on our tax return. Unlike an employee of a larger corporation who receives health insurance as a benefit, our health insurance cost is included as income on our 1040 tax return. Last year, we were only permitted to deduct 25 percent of the first 6 months of our premium. This meant that of the $6,029 of health insurance costs, only $745 was deductible, and the remaining

$5,284 was figured into our taxable income, even though this was a legitimate expense.

We need the enactment of the President's proposal to allow 100 percent deduction of our health insurance costs.

Based on our business income, we qualify for the 3.8 percent cap in the President's health reform proposal. Assuming our premium stays at $5,965 a year, this would yield a savings of almost $3.700 annually, excluding the $2,000 in deductibles we must pay. And even if we were to receive the maximum proposed cap of 7.9 percent, we would still save over $2,500 annually without the deductible.

With the kind of savings President Clinton proposes for us, we would again be able to invest in our business, increase our payroll, and feel secure that we would not be bankrupted by the cost of health insurance and medical care.

Because of the $1,000 per person deductible and the high cost of our premium, we effectively have no coverage for primary care, prescriptions, accidents requiring emergency treatment, diagnostic tests, or other preventive care.

I turned 40 this year and cannot have a mammogram or any other screening because we cannot afford to pay the full cost. For the same reason, my husband cannot have a physical, blood pressure medication, or testing or other screenings. Dental work and eye exams have become luxuries my husband and I try to avoid. We do, however, find a way to see that our 6-year-old receives all appropriate care. To this end, we have budgeted this summer in order to pay for his annual physical in October. It seems to us that the more we pay into the current system, the less secure we are with respect to medical care.

We have also heard a great deal lately about the negative effects President Clinton's proposal may have with regard to choice of physicians, rationing, and the effects of price controls set by a national board. We already have limited choice of physicians and price controls, but they are set by our insurance company through negotiations they undertake with the health care providers. Each year, Blue Cross and Blue Shield publishes a list of participating physicians who have agreed to accept their maximum allowable charge for each procedure. In our case, this means that a physician may charge any amount, but he must accept a combined payment of 80 percent from Blue Cross and 20 percent from us in an amount set by Blue Cross as payment in full. If we choose to see a nonparticipating physician, Blue Cross will only pay 75 percent of their maximum allowable charge, and we must pay the entire balance even if it exceeds the Blue Cross limit. We have changed participating physicians.

Rationing also exists for us now. Those of us with high deductibles are self-rationing due to the economies of the situation. Rationing also exists through the requirement of advance authorization for an ever increasing list of procedures, including hospital admissions, that are not covered unless it is decided in advance that the physician's order is correct. Even if admitted on an emergency basis, we have 24 hours, regardless of our condition, to notify them and request authorization to stay in the hospital. We would

prefer a system in which our medical needs are the sole basis for these decisions.

The President's plan addresses many of our concerns as individuals and citizens. Through the workings of the national board, providers would no longer have an economic interest in the procedures they order, and physicians would be the ones making informed decisions about our care, rather than insurance companies.

Through the use of large risk pools, as we once had, premium costs would be a reasonable percentage of our payroll instead of forcing us into real or near bankruptcy. Universal coverage could reduce the hospital costs that are now being passed on to those of us who still have insurance.

Preventive care would significantly lower the overall health care costs and some Government subsidy programs by treating problems before or immediately after they occur.

Universal coverage would also allow a growing number of people to return to work without the fear of losing the only source of medical insurance they have, which is Medicaid.

And the President's proposal would, by eliminating the rating of subscribers by age and sex, remove the potential for employment discrimination due to the disparity in premiums. In our current system, companies find that young, single males are preferable to middle-aged and older men and women with families, because they are cheaper to insure. Given the choice between two reasonably qualified individuals, employers looking to the bottom line are more apt to hire the applicant with the lease expensive benefits.

For us, the President's proposal would guarantee our insurance, provide us with primary and preventive care, and significantly lower our costs. Although we do still have some questions on the specifics of certain areas, of President Clinton's proposal, we welcome the change he is calling for and sincerely hope this proposal for health care reform will not become the focus of contentious partisan debates designed to prevent its passage.

Thank you.

[The prepared statement of Cyndy Adams follows:]

PREPARED STATEMENT OF CYNDY ADAMS

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Preventive care would significantly lower the overall health care costs and some government subsidy programs by treating problems before or immediately after they occur. Universal coverage would also allow a growing number of people to return to work without the fear of losing the only source of medical insurance they have, Medicaid. And, by eliminating the rating of subscribers by age and sex, the Presi-

dent's proposal would remove the potential for employment discrimination due to the disparity in premiums. In our current system, companies find that young, single males are far cheaper to insure than middle-aged and older men or women with families. Given the choice between two reasonably qualified individuals, employers looking at the bottom line are more apt to hire the applicant with the least expensive benefits.

For us, the President's proposal would guarantee our insurance, provide us with primary and preventative care, and significantly lower our costs. Although we do still have some questions on the specifics of certain areas of President Clinton's proposal, we welcome the changes he is calling for, and we sincerely hope this proposal for health care reform will not become the focus of contentious partisan debates designed to prevent its passage.

Senator WOFFORD. Thank you.

Mike Braxmeyer.

Mr. BRAXMEYER. Senators, I'd like to thank you for having me here to tell our story. Fortunately, I do not have a catastrophic illness to tell you about; I do hope the new reform covers that. I did experience indirectly some of the problems associated with that.

My story deals with a young man who was about 2 years old in 1986. He is the son of one of my employees who is the meat market manager in our supermarket, which, by the way, according to industry standards, just barely qualifies for that name. That's how small we are.

My meat market manager had a son who was 2 years old in 1986, who was diagnosed with leukemia. At that time, the insurance at our business was around $200 per month for individual and a little under $400 per month for family coverage. Our business covers the single person; if our employee wishes family coverage, he picks up the difference. That has worked for 30 or 40 years.

In 1988, the young man, about 4 years old, had a bone marrow transplant. The transplant, according to his mother, cost $70,000 or $80,000. Luckily, our insurance covered that.

In 1988, we received notice from our insurance carrier that our premiums had risen. From a family plan of $697 in 1991, we were informed, with eight people on the plan, that our plan would now run $1,242 per month. Single coverage was $421.

To avoid a lot of numbers games here, that meant that my employee, as long as we stayed with our particular plan, was going to have to come up with $800 per month out-of-pocket. That is $9,600 per year plus, over $10,000.

Needless to say, our employee could not handle that. Neither could my business afford $400 per month individual premium plan. Our plan was not associated with any larger plan, any larger group.

At that time, I was forced as an employer to go out—and I can assure you I lost a lot of nights' sleep; it wasn't only lost sleep, it was anxious time—we are not big enough as an employer to hire a broker to go out and broker our situation—I had to hunt and hunt and hunt, and believe me, if you have a group with eight people, you are not going to find many insurance carriers that want to pick you up. Everyone I talked to would pick up our group except for the leukemia patient, who was in remission at this time, and at 5 years old, was doing quite well. However, he had a lot of medical expenses. He was still collecting from Blue Cross and Blue Shield. His parents to this day take him every 2 or 3 months to Denver, which is 200 miles from our home, for checkups. Three

times a week, he goes up to the local hospital for physical therapy because his left arm has atrophied to a certain extent. He has to have wax treatments and physical therapy on that arm. All his teeth are capped because some of the anti-rejection drugs essentially ate those teeth away. He has high blood pressure because of some kidney problems, which is directly related to the bone marrow transplant. This young man and this family still have a lot of expenses.

Anyway, back to 1991. We are hunting for a plan. I cannot find a plan that will cover my employees, and one very loyal employee who has gone through a living nightmare trying to keep his son alive, like some of these three people behind me are trying to do. But I cannot find a plan that will cover him, and I sure can't afford the single premium, and that employee cannot stand $800 a month plus the deductible.

We settled on a plan that costs me $205 single coverage and $428 family coverage. However, that plan ridered that young man for $5,000. There is a chance that might have covered it, but his folks could not play that game. They went out and bought a single plan for him for $119 a month. At this time, it is now $130 a month with a $2,500 deductible. They are paying $130 a month for that single plan for that young man. They are paying approximately $200 to pick up family coverage for the rest of the family. They are meeting a $2,500 deductible yearly, which I'm sure they are using up—actually, it should probably be them and not me standing here before you. This young may is about 8 or 9 years old now and in school with the rest of the kids his age in our community. He is one of five out of twenty out of his class at the University of Iowa who had a bone marrow transplant who are now alive. Believe me, his folks have a lot of faith, and that family of seven has pulled together.

Anyway, back to the situation. He is paying $300 to $400 out-of-pocket right now, and I am covering him on our health plan.

I am here today because of pre-existing condition problems, and I think we are all aware of it. And after listening to the testimony today, I think we need to pay attention to catastrophic illness. I am not sure our problem—and I am not going to preach, because I don't know the numbers—is not so much basic health insurance as some catastrophic problems. A catastrophic problem is really the reason why I am here. It is a major problem for my business.

That is what happened to the business. Let me sit here before you as an employer—and I have heard some sorry stories about employers who were not honest or who did not want to take care of their employees—I am from a small town in a small State with few people. We have some problems. My employees are valuable to me. I could not leave my employee, this meat market manager, hanging out there without some coverage.

Some of the plans I went to told me one way to get around this was to fire the meat market manager, and 2 days later hire him back; they'd have to take him. Those are the kinds of things we don't get into out our way, and I am afraid of those. I am a small enough business that I don't have a lawyer or an accountant or a consultant on retainer. I deal with most of these problems myself.

It is a hands-on business. I really cannot speak to the larger businesses that were referred to earlier in the testimony.

Anyway, as far as businesses go, you folks are about to saddle the employers in this country with the burden square on their shoulders. And I'm not sure we shouldn't cover it. I personally feel we should, and I'm willing to do it. I don't know what percentage of my payroll goes directly to health insurance premiums right now. I have 13 employees that I pay $205 a month on. I am willing to go more if that's what it takes to cover them. Please make sure your plan covers them.

It is also a choke-hold or a strangle-hold you are going to put on our shoulders and around our necks. All I ask as an employer—and I'm not sure I represent the employers in Kansas and in this country; I'm awfully small—but I ask you to try to take care of all situations as best you can. You are taking cost questions and choices right out of our hands.

We will no longer determine in companies, if I understand the plans right—and Senator Kassebaum's, I have looked at thoroughly; I like the plan—please hear me; I'm an employer, and I like the plan, and I am willing to pay. I think it is a good plan. But 5 and 6 years from now, the commissions making decisions, are we going to have some Medicare coverage slipped in on us? What about home health and long-term care?

I'm not sure maybe we shouldn't be paying some of those, but please be up-front with those charges. We have an independent manufacturer in my home town—a town of 1,500 people, 3,000 in a county of about 900 square miles—we have a small manufacturer who used local funds, 10 or 12 years ago, to start a manufacturing company. Right now, I believe they employ between 60 and 75 people. They do not have an insurance plan. I understand they are looking at one right now. Depending on what legislation you folks pass up here, they will or will not be in business 2 or 3 years from now. I think it will weigh heavily on them. Indirectly, my business depends on that.

I think most employers want to work together. I guess one of the last things I'd like to say is let's do this together—employees, employers, and you folks in the Government making the decisions—I think we're all willing to do that.

Last but not least, a pitch for rural health care. On October 1, 1992, you folks designated a community health center for our area. You helped fund it, and it is active at this time. I happen to be on the board of directors of that organization. I think it is a salvation for rural care in America. I think it is probably where you are going with some of your legislation, and I applaud that. I think the Public Health Corps is essential to health care in rural communities. You are also helping with that.

Our particular organization is a multicounty, multiState organization. We have two counties in Kansas and one in Nebraska. It is working well, and I hope you consider that in the legislation.

Thank you.

[The prepared statement of Mr. Braxmeyer follows:]

Prepared Statement of Michael Braxmeyer

Good afternoon senators. First I thank you for the opportunity to address your committee. Having spent the last several days knowing that I had this opportunity, trying to determine just what I needed to say, it came down to three major topics.

But before that--just some kind of introduction. My name is Mike Braxmeyer. My age--44. Married for 22 years with three children. My wife, Rosie, is from a small community in Central Kansas. My oldest daughter is at Kansas State, Adam is in high school, and Emily is in grade school.

I was born in Oregon, raised in Atwood, Kansas, graduated from high school there and from Kansas State in 1971 with a degree in economics. I was employed by K-Mart from 1971 to 1974 in Des Moines, Chicago, and Milwaukee.

My wife and I moved back to Atwood, Kansas, in 1974 to manage my family's business and to raise our family in rural USA. The business is Williams Brothers, a supermarket begun by two brothers in 1938. As a business we employ 11 people full time and 15 to 20 part time. As for size, we have 10,000 square feet of floor space and do just enough volume to be classed a supermarket--by industry standards. Atwood is a town of 1,500 in a farm county of 3,700 people and 950 square miles. We are located 200 miles from downtown Denver and 400 miles from Kansas City in the very northwest corner of Kansas. The nearest town over 10,000 people is 140 miles distant.

I would like to make several points.

Some kind of health reform is necessary! Here's our story.

In 1988 we had an independent group of about eight employees on a health plan costing less than $200 a month for single coverage and $400 for family coverage. We were independent--not associated with any other groups. For years we have covered our full-time employees by paying 100 percent of their premium, and if they desired family coverage, the employee funded the premium over and above the single rate. At that time, the company was paying right at 50 percent of the total, and I believe we had three or four enrolled in family plans.

On August 7, 1986, Roman Carroll, aged two, was diagnosed with leukemia. Roman is the youngest son of our meat market manager, Pat, who was enrolled in the family plan. As I'm sure you all know, it was devastating for the family of eight. After nearly two years of expensive treatments and heartaches, Roman was taken to the University of Iowa at Iowa City for a bone marrow transplant, the donor being Roman's oldest sister, Gina. The operation was successful and today Roman is in school with others his age. He has some health problems relating directly to his condition and may have many more. He has had all his teeth capped and experiences high blood pressure due to his disease and medications. One arm has atrophied slightly, and he undergoes physical therapy three times a week. He takes numerous medications to prevent donor rejection and to alleviate side effects. He travels to Denver every other month for checkups and to Iowa City for examinations yearly. Needless to say his family has undergone many anxious times, and it has been an ordeal for them.

But faith has not paid the bills. I have watched Pat, the father, my employee, suffer through the threat of losing his son and the worry of covering bills. Pat's wife, Madge, has suffered with Roman and also dealt with endless paperwork trying to pay uncovered services as best they are able. She is still paying for medications not covered, and because of a Kansas insurance policy, she still has to hassle with bills from Iowa and Colorado where coverage is fuzzy. Here are some figures.

Their report:

In 1991	. Roman	$109 a month	$1,000 deductible $1,000 Co-Insur.
In 1992		$119 a month	" "
In 1993		$159 a month	" "
Changed to $130 a month with $2,500 deductible			

Store Report:

1991 preimums

March	$ 240	single
By this time down to one on family	$ 697	family
May	$ 421	single
	$1,242	family
	$ 821	diff. 1992

Pat $130 premium
$200 deductible
$223 single to family diff. IGA Group Insurance Trust
$553

Result in 1991--Absolutely unable to pay those high premiums even for single coverage. No family is able to pay $821 a month for family coverage plus $500 deductible. By this time, three of the four families had gone elsewhere--my own included.

Many, many, not just sleepless nights, but anxious time. We could not afford this policy, Pat had to have coverage for Roman, no other plan would accept Roman except on a rider for his condition, we're not large enough to broker.

Result: IGA group Insurance with $154, $299 premiums but riders (5,000 on Roman and one on heart medication and one on allergies, etc.

Madge and Pat still estimate that they pay $100 to $200 a month on medical bills dating back to Roman's $76,000 transplant.

Who will pay for the health of this country's people?

Voluntarily, for say 40 or 50 or more years, employers have paid for more and more health benefits of employees. I guess we've done this to keep our employees, to reward their dedication over and above their pay. Both large and small employers alike to varying degrees have paid for the health of employees. Now its cost has "EXPLODED," and Washington would like to mandate employer payments. Maybe we voluntarily have put ourselves in this position as employers. Fifty or 60 years ago would this have been expected of us. Twenty or 30 years from now will employers be mandated to pay room and board, or the education, primary, secondary, college, along with vocational tech, of our employees' families--or maybe vacations.

Possibly you'll interpret this as a small businessman attempting to backpeddle or avoid business costs. Please understand, one health care needs to be revised, but two, you're laying it on our shoulders. Please do it gently. Business as a whole believes in helping pay our employee's health costs. But more than NAFTA, more than FICA, more than minimum wage laws, this has the potential to choke and strangle the life out of businesses, large and small. I know I sit before you with some small numbers--small town, small business, rural small state--and I'm sure I am looked on as a small business, but I do believe if this is not handled justly and delicately , a lot of us large and small will suffocate. Three or four years from now, some businesses will not exist because of this reform. Honest employers who would like to share health costs with their employees--good sound businesses who were simply put out of business because of the legislation you're going to pass. Again I say this not to undermine your reform but to ask you to be careful with this potential choke.

Costs will now be out of our hands. Insurers and providers and alliances will now determine costs. Increases will be determined by your appointed national health board or alliances.

I would also like to add, please continue to support community health centers and the Public Health Service Corps. These are vital to rural health care.

Senator WOFFORD. Thank you. You and Cyndy Adams both are doing what people all over this country are doing. They are not only thinking about their own problems, but they are thinking about how we ought to fix the problems of the country on this. We very much want the kinds of suggestions that both of you have put in terms of where we go from here, as well as putting so clearly to us your own situations.

Tomaca Govan, your Senator Dodd very much wanted to be here to welcome you and ask questions; he is on another assignment now, however, and may not make it, depending on how long we go.

Please go ahead.

Ms. GOVAN. Thank you. Good afternoon. Thank you for having me here today.

I am a small business owner from Hartford, CT. I am married, and I have three children. Currently, my family has no health insurance. My husband has a part-time job and is looking for full-time employment with the medical benefits that we need.

I had insurance with an HMO through my previous employer. I left my job earlier this year, after I had a baby, to start my own business. I expected to keep my insurance for 18 months through COBRA coverage. The insurance premium for myself, my husband, and our three children was $462 per month. This amount was pretty steep, but I knew I had to have insurance for myself and my family, and I just figured okay, if that's what it is, I'll just have to pay it every month. I also believed that if at some point down the road, the expense of this HMO coverage, which is top-of-the-line medical insurance, was too expensive, that I could easily change over and get insurance that did not cost as much because it wouldn't cover as much.

I was unprepared for my business income to waiver and fluctuate as it did over the summer. I knew I wasn't going to be able to keep paying almost $500 per month for insurance, so I began looking for other options. I had no idea how hard it was going to be to find coverage that was comparable to what I had and that was affordable. Affordable, comprehensive medical insurance—I didn't think that was too much to ask for, but it was.

I started by going through the yellow pages. As I called different insurance companies and agents, my initial shock turned to anger and frustration. It was also very frightening. I learned that finding anything that was remotely comparable in terms of coverage and price was impossible. Either the cost was a little less than what I was paying and covered only emergency care, or it was more expensive and offered less than the same level of care that I had.

Many insurance companies did not sell insurance to self-employed individuals and their families. I did not know this. I fell under a separate category and was referred to companies that I had never heard of before to obtain insurance. I called several of these companies. Most of them would not give me information over the phone and would not send me any brochures or other documentation in the mail to review. They insisted that they be able to come over and personally show me their insurance plans.

I agreed to look at two plans from two different companies. These people came to my house with big binders and showed me page after page as they discussed each one. It reminded me of meeting

with Amway salespeople. We reviewed what I considered to be "rickety" insurance plans, where I could pick and choose coverages and deductibles. Then they tried to press me for an immediate decision.

It was clear that they only wanted to walk out of my house with my check in their hand. Also, one of the salespeople could not fully answer my questions. Again, these were companies I had never heard of before; they were not regulated by the State of Connecticut, which means that there are specific requirements and guidelines for coverage that the State of Connecticut has that these companies were not required by State law to provide.

I was afraid of signing up with one of these companies. I envisioned my monthly premiums just disappearing into never-never land every month, and I seriously wondered if the insurance was really real. And if I did have to go into the hospital, would that insurance be there and would it be useful?

I knew that eventually, I would lose my medical insurance coverage completely. I began to panic because I could not find anything. And I was told by many companies that I had to be insured already in order to get insurance. That doesn't make sense to me.

I have an infant who is now 7 months old. Before I lost my medical insurance, I went to my HMO carriers and tried to insure just the baby. That way, at least he would be taken care of, and I would not have to worry about the out-of-pocket costs for vaccinations and doctor visits. Also, because infants are fragile, they tend to contract colds, ear infections and other viruses easily, and having access to good medical care is very important. I figured that as soon as business picked up, I would be able to add other family members to the insurance as our income allowed. This was an ideal plan to me. I would pay a much lower monthly premium for just one person instead of the whole family. I would still have an "in" to the HMO, and family and I could feel confident with keeping the same level of medical care that we had for years.

However, I was not able to insure the infant only. One of the parents had to have coverage, too. The cost for two people in this HMO was over $300. This, again, was something I just could not afford, so I had no choice but to let my insurance go.

Currently, my family does not have medical insurance, and we are afraid. We are afraid to be without it. I realize that a hospital cannot refuse emergency treatment to anyone. However, it is all the nonemergency situations that may arise that I am worried about.

I have a very active 7-year-old son, and because boys are boys, what do I do if he falls off his bike and breaks his arm? I am also concerned about us needing to go the doctor for checkups and illnesses and prescription medication. These things would have to be paid for out of our pockets.

I am greatly disillusioned. I decided to take a risk and take my shot at the American dream by starting my own business. If I had known that finding insurance would be this difficult, this frustrating, and this frightening, if I had known that it was totally unaffordable, then I would not have quit my job. I would have stayed there and explored other options. I knew that insurance was expensive, but I had no idea just how expensive. I honestly thought

that I could obtain affordable medical insurance. I thought it was just the HMOs that were hundreds and hundreds of dollars per month.

I know many people like me who have dreams of self-employment, but are forced to keep their jobs because they are afraid to be without medical insurance for themselves and their families. Our country and our communities are denied their brilliance, they are denied the economic stimulation and growth that these new businesses would bring.

President Clinton's plan makes sense to me. It doesn't just offer affordable insurance—and to me, the key is affordable—it offers a comprehensive benefits package. I will know what I am getting. And most importantly, that insurance is going to be there, regardless of what my income is, where I work, or where I live in the United States.

I need to be able to provide medical protection for my family, and from what I have heard, President Clinton's plan will allow me to do that, and it will also allow me to freely continue to pursue my quest for success as an entrepreneur. And I know I speak for many other people back home in Connecticut.

Thank you.

PREPARED STATEMENT OF TOMACA GOVAN

My name is Tomaca Govan. I am the owner of a small business from Hartford, CT. I am married and have three children. Currently, my family has no health insurance.

I had insurance with an HMO through my previous employer. I left my job earlier this year to start my own business. I expected to keep my insurance for 18 months through COBRA coverage. The insurance premium for myself, my husband, and our three children was $462/month. This amount was pretty steep, but I knew I had to have insurance for myself and my family and I just figured "Okay, if that's what it is, I'll just have to pay it every month." I also believed that if at some point down the road the expense of this HMO coverage, which is top of the line medical insurance, was too expensive, I could easily change over and get insurance that didn't cost as much because it wouldn't cover as much.

I was unprepared for my business income to waver and fluctuate, as it did over the summer. I knew that I wasn't going to be able to keep paying almost $500/month just for insurance. So I began looking for other options. I had no idea how hard it was going to be to find coverage that was comparable to what I had and that was affordable. Affordable, comprehensive medical insurance: I didn't think that was too much to ask for, but it is.

I started by going through the yellow pages. As I called different insurance companies and agents, my initial shock turned to anger and frustration. It was also frightening. A lot of companies would not offer insurance to self-employed people. I learned that finding anything that was remotely comparable to what I had before in terms of coverage and price was impossible. Either the cost was a little less than what I was paying and covered only emergency care, or it was more expensive and offered less than the same level of care that I had. Many big name insurance companies did not sell insurance to self-employed individuals. I fell under a separate category and was referred to companies that I had never heard of before to obtain insurance. I called several of these companies. Most of them would not give me information over the phone and would not send me any brochures or other documentation in the mail to review. They insisted that they be able to come over and personally show me their insurance plans.

I agreed to look at two plans from two different companies. These people came to my house with big binders and showed me page after page as they discussed each one. It reminded me of a meeting with Amway sales people. We reviewed what I considered to be "rickety" insurance plans, where I could pick and choose coverages and deductibles. Then, they tried to press me for an immediate decision. It was clear that they only wanted to walk out of my house with my check in their hand. Also, one of the salespeople could not fully answer my questions. Again, these were companies I had never heard of before. They were not regulated by the State of Con-

necticut, which means that there are specific requirements and guidelines for coverage that the State of Connecticut has, that these companies were not required by law to follow.

I was afraid of signing up with one of these companies. I envisioned my monthly premiums just disappearing into never-never land every month, and seriously wondered if the insurance was for real. And if I did have to go into a hospital, would that insurance be there and be useful?

I knew that eventually I would lose my medical insurance coverage completely. I began to panic because I couldn't find anything. And I was told by many companies that I had to be insured already in order to get insurance. That doesn't make sense to me.

I have an infant who is now seven months old. Before I lost my medical insurance, I went to my HMO carrier and tried to insure just the baby. That way, at least he would be taken care of and I would not have to worry about the out-of-pocket costs for vaccinations and doctor visits. Also, because infants are fragile, they tend to contract colds, ear infections, and other viruses easily, and having access to medical care is very important. I figured that as soon as business picked up I would be able to add other family members to the insurance as our income allowed.

This was an ideal plan to me. I would pay a much lower monthly premium for just one person instead of the whole family. I would still have an "in" to the HMO and my family could feel confident with keeping the same level of medical care that we had for years. However, I was not able to insure the infant only; one parent had to have coverage, too. The cost for two people in this HMO was over $300. This, again, was something that I could not afford, so I had to let my insurance go.

So, my family currently does not have any medical insurance. I am afraid to be without it. I realize that a hospital cannot refuse emergency treatment to anyone. However, it's all the non-emergency situations that may arise that I am worried about. I have a very active seven-year-old son. And because boys are boys—what do I do if my son falls off his bike and breaks his arm? Or if someone in my family needs to have surgery? I am concerned about us needing to go to the doctor for check ups and illnesses, and prescription medication that would have to be purchased: these things would have to be paid for out of our pockets.

I am greatly disillusioned. I decided to take a risk, and take my shot at the American dream by starting my own business. If I had known that finding insurance would be this difficult, this frustrating, and this frightening, if I had known that it was totally unaffordable then I would not have quit my job. I would have remained there and explored other options. I knew that insurance was expensive, but I had no idea just how expensive! I honestly thought that I could obtain affordable medical insurance. I thought it was just the HMO's that were hundreds and hundreds of dollars per month.

I know many people like me who have dreams of self-employment, but are forced to keep their jobs because they are afraid to be without medical insurance for themselves and their families. Our country and our communities are denied the economic stimulation and growth that these new businesses would bring.

President Clinton's plan makes sense to me. It doesn't just offer affordable insurance, (and the key here is affordable) it offers a comprehensive benefits package. I will know what I am getting. And most importantly, that insurance is going to be there, regardless of what my income is, where I work, or where I live. I need to be able to afford medical insurance for my family. President Clinton's plan will allow me to do that. It will also allow me to be able to continue my own personal quest for success as an entrepreneur.

Senator WOFFORD. I thank all three of you.

Senator Kassebaum.

Senator KASSEBAUM. Thank you all very much.

I will start with Mr. Braxmeyer. First, I will say that he drove 200 miles in order to get to the airport in order to get to Washington. It is a far piece out in the western part of the State.

I have not supported employer mandates. That is one difference that I have had with the President's approach. Was that something that you were indicating, perhaps, in your comments, Mr. Braxmeyer, that you would have some difficulties with an employer mandate? Or, do all three of you believe the employer mandate is important—the 80 percent/20 percent contribution.

Mr. BRAXMEYER. I personally believe in it. We have done it, Senator Kassebaum, in our business for—I came back in 1974. It is a family business. I don't know how many years it was going on before that. I believe in it personally, and from what I read in the papers back in Kansas, Capitol Hill is heading that way. And I do not see any way to avoid that.

Right now, I don't see that the public can stand an income tax, or a sales tax, whatever kind of taxes are available, so I support employer involvement. It looks like possibly, if I put the figures to it correctly, it could save me money personally. Now, I want to make sure my employees are covered as well as they are now. I have this leukemia patient, and I don't know if they are anxious to trade doctors right now.

What concerns me a little bit is all the alliances amongst providers that might get together. We are out there in virtually nowhere. I am 400 miles from Kansas City, and the nearest town over 10,000 is 100-plus miles. It bothers me a little about the alliances that may be formed amongst providers. That's why I really endorse the community health centers. I think they are the answer for us out there.

Back to your question, I do endorse employer involvement.

Senator KASSEBAUM. Do you believe that's true for the other employers in Atwood? You mentioned the small manufacturer there who brought certainly some employment to the area.

Mr. BRAXMEYER. He is essential to our community of 1,500. They are looking at a plan, I understand. Now, how extensive that plan is—if that plan is as extensive as the plan you have outlined or President's plan, I don't know. I would think it would depend on the premiums involved. I don't know what coverage they are looking at.

Senator KASSEBAUM. You didn't ask necessarily about an employer mandate in visiting with them?

Mr. BRAXMEYER. No, I did not.

Senator KASSEBAUM. One other aspect of this, of course, that has been a real problem in Kansas is the escalating cost of workmen's compensation. That is affecting other States as well, but I know in Kansas it has really become a high cost of doing business. Is that a problem for you? Would you feel it would make it more attractive if workmen's compensation were rolled into the basic benefit package, if that can be worked out. That's something that is not in the President's plan at this point.

Mr. BRAXMEYER. I just came from an industry meeting in Kansas City a week ago, where we spent an entire afternoon on this. Statewide, the State of Kansas has a very liberal workmen's compensation package. I am going to pay 4 percent next year. I'll pay about $10,400, my agent tells me, for workmen's comp. Since 1982, I think I have had eight or maybe nine claims, amounting to less than $4,000 in 11 years. I'll pay $10,000 this year.

Depending on how it is managed in Washington, DC, I think most employers in Kansas would like to see that considered. However, I would like to see that considered as a separate measure over and above or side-by-side with health coverage for employees; in other words, separate accountability, so it is not all rolled into one package. One package premium-wise, but let us look at that as

an employer or as a business and say, well, so many dollars are going for workmen's compensation and so many dollars for health care for our employees. I would welcome that, I think, at least the consideration of that.

Senator KASSEBAUM. I would just say to Ms. Adams and to any self-employed person that I think there is total agreement here that there should be 100 percent deduction for the basket of benefits. I think you would find that everyone believes that the 25 percent limit is an inequity that should not be continued.

I thank you. I certainly appreciate all three of you coming. It is going to take a long time for us to sort out—for some of us, maybe longer than others—some of the complexities of this, but everybody who has testified points to some of the real concerns that we have to try and find answers for.

Thank you, Mr. Chairman.

Senator WOFFORD. Let's explore the employer mandate and the employer costs today with all three of you. Mr. Braxmeyer was saying that as he perceives the President's plan, it would probably save him money.

Would you just give me your analysis on that to see whether we're on the same wavelength?

Mr. BRAXMEYER. I'm not sure how accurate that estimate is, Senator. I base that on the fact that we pay $205 a month for 13 employees.

Senator WOFFORD. The 7.9 percent cap on payroll might help you?

Mr. BRAXMEYER. I think that is probably in the neighborhood of where I am at now. The thing I am not sure about is family coverage involved in that and especially part-time coverage. Some of my part-time employees also work other places. Some of them are dependents under other family coverages, and I am not sure where I would fold into that cost-wise.

Senator WOFFORD. In the President's plan, family and part-time are both specifically covered in ways you need to look at. But a big item for you is that the rating of that, whatever the premium is in your region, would be for everyone in that region and not based on your own company's experience, so that the high cost of an employee with leukemia would be shared across a large pool and not imposed on you.

Mr. BRAXMEYER. That is the attractiveness of this package. We were an eight-member, stand-alone, group insurance, and when this catastrophic illness hit us, that's exactly what happened. We also have some minor heart conditions involved in our group and some typical allergies and things like that, but I personally do not feel that was the reason for the jump; it was the catastrophic illness.

Senator WOFFORD. And as you perceive, one of the reasons for the alliances or the big purchasing cooperative pools, is so that you would have the benefit of big purchasing power that large corporations now have and large State employee programs have.

We are being buzzed by something, Senator Kassebaum. I think there is a vote on.

Senator KASSEBAUM. There is a vote on, I hate to say.

Senator WOFFORD. Which means we have just a few minutes.

The percent of payroll that Cyndy Adams referred to, I think you said you had reached 30 percent; is that right?

Ms. ADAMS. Right now, we project 21 percent this year. But when you have your monthly health insurance for one family plan exceeding your payroll tax deposits each month for 6 months, it's a bit rough. We see the President's plan, if they couldn't lower our premiums for 1 year, we would still save $3,700 plus the $2,000 in deductibles that we pay out. It would be a substantial savings for us right now if that were to take place.

Senator WOFFORD. Would there be some savings in terms of time and investment in the health plans if there were one large regional purchasing alliance, where you paid to that alliance the premium, but the administering of the plan and the choices the employees and you would have would be a menu that everybody in the whole region would have, and you would not be individually negotiating it each year?

Ms. ADAMS. That would probably help our association. The association still administers it, but we are not a large group anymore.

Senator WOFFORD. But your story suggest that a lot of small businesses want or feel the need to have health insurance, but that it has gotten out of reach.

Ms. ADAMS. That is exactly right. We have some members who have had their insurance increased by 168 percent in that first year of de-grouping, and it was a phenomenal increase. Those people dropped out immediately. And that was for a two-person plan.

Senator WOFFORD. We will want to hear your thoughts as the proposals for the health alliances and how they are organized and shaped come before the committee, and we start crafting it, because there will be a lot of concern on this committee to make sure that they are organized in such a way that they represent you and your employees. Under the President's proposal, a provider is not permitted to be in the alliance. The alliance is to represent you, dealing with the providers. So you need to follow this as we go to see that we live up to that. The theory of it is that those alliances would be nonprofit corporations that you will be represented in, businesses and employees, and not the providers, so that it deals in strength on your behalf with the providers. That is the theory. We have to see if we can shape it in such a way that it leads up to it.

I guess we are coming to the end. Tomaca Govan, would you like to give us any last words on this? I'm sorry that this is being cut short. I know that you all have to leave for plans, so that by the time we got back in 20 minutes or so, it wouldn't make sense to try to continue. But do you have a last thought for us?

Ms. GOVAN. Well, basically, I really think it is important for everybody, the citizens as well as Senators, to just keep track of what is going on and to make sure to let our representatives know what our needs are.

That's basically it—everybody pay attention to what is going on.

Senator WOFFORD. We are delighted that you are, all six of you today, and we look forward to keeping in touch with you as we move forward.

Thank you for this afternoon, for this whole day, and for the long drives and flights that you took.

The committee is adjourned.
[Whereupon, at 3:10 p.m., the committee was adjourned.]

THE HEALTH SECURITY ACT OF 1993: VIEWS OF HEALTH CARE PROVIDERS

TUESDAY, OCTOBER 5, 1993

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10:05 a.m., in room SD–430, Dirksen Senate Office Building, Senator Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Metzenbaum, Simon, Bingaman, Wellstone, Wofford, Kassebaum, Jeffords, Coats, Gregg, Hatch, and Durenberger.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. We'll come to order.

All of us know that the American health system is in crisis. No American family can be confident that the health insurance that protects them today will be there tomorrow if serious illness strikes. Costs are out of control. Excess medical cost inflation threatens to price care out of reach for individuals and families, and it is a major burden on the economy, the Federal deficit, and the ability of businesses to compete in world markets.

The system is overflowing with red tape and excessive administrative costs, which affect doctors, hospitals, nurses, and patients alike. Large numbers of citizens—even those with insurance—increasingly find their choice of doctors limited by insurance companies and their employers.

Much is wrong with American medicine, but there is also much that is right. U.S. doctors, nurses, and hospitals provide the best medical care in the world. We are the world leader in biomedical research.

The President has proposed a bold, comprehensive plan to fix what is wrong with the health care system while preserving what is best. There is broad bipartisan agreement on the basic goals that President Clinton has set out, and in the coming weeks, Congress will be working closely with the administration to write legislation achieving these goals.

This hearing is the fourth in a series that the Labor and Human Resources Committee is holding on the President's plan. We intend to explore this proposal in detail and to give it the highest priority.

Today we will hear from representatives of major organizations representing the views of doctors, nurses, and hospitals. The support and cooperation of health care providers is essential for health

care reform. Those who provide the care are the ones who will make reform work. They see the problems of the current system firsthand, and they have an indispensable contribution to make in helping to define the problem and developing workable solutions.

Those on the front lines of health care share the same sense of urgency felt by the American people. They know it is wrong when patients cannot receive necessary care because insurance will not pay, or lose the savings of a lifetime because they become ill.

Often, they spend more time filling out forms and talking on the telephone to insurance companies than treating patients. Too often, they see patients in the emergency room with serious illnesses that could have been avoided or easily treated by earlier care. Too often, continuity of care is interrupted when an employer changes health plans, and patients must change doctors.

At the same time, providers have legitimate questions and concerns about the consequences of reform for themselves and their patients. I am prepared to work with them to resolve their concerns, and I know the President is as well.

From the point of view of someone who has been involved with this issue of comprehensive health care reforms for some period of time, the striking thing is not the concerns that health providers have expressed about the President's plan, but the unprecedented degree of agreement and enthusiasm about many of its central provision, the recognition that comprehensive reform is essential, and the strong desire by everyone to work constructively together to finally pass legislation that will assure health security for every American.

The representatives of the leading health provider organizations who are here today will address many of the issues posed by the plan—both the areas of agreement and the areas that may need adjustment. I welcome their participation and look forward to their testimony.

Senator Jeffords.

OPENING STATEMENT OF SENATOR JEFFORDS

Senator JEFFORDS. Thank you, Mr. Chairman.

It is a pleasure to be here this morning to discuss the Health Security Act with various health providers. No group is more important to health reform than, of course, are the providers. Providers are the health care system. I doubt health care reform can be successful unless most providers want to make it a success.

As many of you know, in my own State of Vermont, we are on the verge of enacting our own State health care legislation. We have already enacted numerous significant reforms, all aimed at making the most of each health care dollar spent throughout the State.

I don't think any State is more efficient nor does any State have any higher expectations concerning health care than does my State. I believe the State of Vermont is at present the only State that already has a State health care budget. For a one-year period starting this past July, our budgets take the form of expenditure targets and are frequently phased in.

For the past 10 years, Vermont has enacted statewide budget review process for hospitals, continuous quality improvement pro-

grams for outcomes research, a Medicaid supplement for children and families of up to 225 percent of poverty, and insurance market reforms requiring community rating and guaranteed acceptance.

Many people have asked me how Vermont was able to accomplish such sweeping reform. The answer is simple. In Vermont, no decision on health care has been made without the advice and the support of the providers. Nobody knows more about what is wrong with our health care system than do the providers. We must seek and rely upon their expertise to make it better.

That is why, Mr. Chairman, I look forward to hearing the panelists today. I appreciate your holding this hearing in order to provide all the committee members an opportunity to hear what they have to say and to work with them in order to make this a workable system.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Metzenbaum.

OPENING STATEMENT OF SENATOR METZENBAUM

Senator METZENBAUM. Mr. Chairman, I commend you on holding this hearing today, and I am looking forward to hearing the testimony of today's witnesses, some of whom I have worked with very closely in the past and some of whom have been naysayers and have been very difficult to get to the negotiating table.

Clearly, health care providers play a crucial role in our health care system and must play a key role in any reform plan. But the ultimate test of reform must be that it serves the needs of the patients.

I think what we have found now in America is a situation where the American people very, very much want a health care plan. The don't know how to go about; they don't know the intricacies; they don't know the details. But those who stand in the way of providing a health care plan for all Americans will not be very popular with the American people.

Most Americans do not understand all the details about health alliances and some of the other terms that are being used at the present time. But they do know this—they are afraid of the future. They are afraid of getting sick, they are afraid of their children getting sick, and they want some action.

So I say to those who are the providers, the system needs you very much, but the American people are demanding of you a sense of cooperation. They feel that they are entitled to it; I think we in Congress feel they are entitled to it. We respect the professions, we respect the people in the professions, we respect the providers, but we also respect the demands of the American people.

I found over the weekend a rather interesting phenomenon among a number of my friends who are members of the medical profession with whom I was spending some time—there was a general consensus, a general feeling, that we want something to work. They don't want to be the ones against whom fingers are pointed. And I am hopeful that the American Medical Association and the various other associations will see fit to join with us in moving forward and being supportive rather than standing in the way.

I am pleased to say that the American Hospital Association and I have had a good working relationship to date; we have made great progress; we have brought about some new guidelines at the antitrust division, and I am sure we will hear more about that from Mr. Davidson as he speaks.

But I do call upon those who are the providers to join with us in coming up with the answers and not standing in the way.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Senator Coats.

OPENING STATEMENT OF SENATOR COATS

Senator COATS. I don't have an opening statement, Mr. Chairman, but I am pleased that we are holding these hearings. I think there is a great deal to learn about the system. It is extraordinarily complex. Many, many parts go into making up the whole in terms of health care delivery.

Assessing exactly what the problem is and providing an adequate solution to the problems is a huge challenge for this Congress. I hope that we can do so on an objective basis. There is much to learn about the impact of the President's proposed plan. Hopefully, there is much to learn about alternatives that will address the very real problems that exist within the health care delivery system.

I think we all understand and agree that reforms need to be made. The question is which reforms, how will they be implemented, and what will the ultimate impact be on the ultimate consumer of medical care.

It is one thing to look at a nicely drafted plan that might look good on paper. I think the question, as the Senator from Ohio has stated, has to be what is the ultimate impact on the recipient of the medical care.

Certainly, within our system, we have many who are very pleased with the care that they are receiving; we have others who are not receiving care or are not happy with the level of care they are getting.

Making sure that we don't turn the tables upside-down to provide better care to some at the expense of others, but having the goal of providing sufficient and quality care to all Americans I think is a worthy goal that we need to work toward, and I hope we can do so on an objective basis. I for one have a great deal to learn in terms of how all this works and am looking forward to the testimony of the witnesses.

The CHAIRMAN. Thank you, Senator Coats.

Senator BINGAMAN. Thank you, Mr. Chairman. I really just came to hear the witnesses.

Thank you.

The CHAIRMAN. Thank you.

Senator Gregg.

OPENING STATEMENT OF SENATOR GREGG

Senator GREGG. Thank you, Mr. Chairman.

I also came to hear the witnesses, but I do think that prior to the witnesses speaking, there are some areas that we need to address.

Obviously, the objective here is to maintain a high-quality system and to contain costs. And as we talk to these health care providers, a question which I hope they will address is how they see the various plans which are being considered affecting, one, quality, and two, cost.

For example, the Clinton proposal has suggested that we take approximately $238 billion out of the system in the area of Medicaid and Medicare. Now, I have to presume that most of that is going to come out of the hospital community and out of the physician community, in some way or other, and I would be interested in the views of the hospital and physician communities on how they feel they can deliver quality in light of that sort of a contraction in the amount Medicare/Medicaid payments and whether or not they feel that there is some conflict there.

Also, I am interested in knowing how global budgeting and premium caps which may be put in place by the national boards and standby price controls are perceived within the community in affecting quality of care, because the bottom line here is quality of care, and the question is whether or not this proposal that has been put forward by Mrs. Clinton and the President is an academically driven event which may not have taken into consideration the reality of the hands-on deliverers of the service. So I will be interested of a review in that framework.

Thank you.

The CHAIRMAN. Thank you, Senator Gregg.

Senator Wellstone.

OPENING STATEMENT OF SENATOR WELLSTONE

Senator WELLSTONE. Thank you, Mr. Chairman. I apologize for being late. I was in a mark-up of the Committee on Energy and Natural Resources.

I would like to thank all of the panelists for being here today. I really do believe that all of you have made an enormous contribution. I cannot remember a time in my adult life—and certainly the chairman has been the leader in the United States Congress on this—when we have been as close in our country to adopting what I think will be significant health care reform.

There are a couple of questions or issues, though, that I would like to highlight today with you that I would be very interested in your reaction to. In Minnesota when I talk to caregivers, one of the concerns that they do have about the managed competition framework, based upon current experience, is the concern about being micromanaged, the concern about what damage might be done to the traditional doctor/patient relationship, which I think is very, very important not only to the caregivers but also to consumers as well.

There was a piece in the business section today, and later on I'd like to zero in on this, and the title is, "Thinning the Health Care Herd." It is about recent health care mergers. And I think if there is any concern that I'd like to share with you all today and talk with you about, it's this whole issue of the big insurance companies

coming in and buying up managed care networks, and whether we have a real danger of medicine going oligopoly. The bottom line is clearly not the only line, and I worry about where caregivers fit into this. I would like to get your reaction to a proposal that I certainly want to make, which is that in any health care plan, caregivers—and I define that broadly—doctors, nurses, nurse practitioners, occupational therapists and so on—are going to have to have access to capital so they can set up their own independent networks and not have to hang out a Prudential sign or whatever.

I wonder what your reaction might be to that kind of proposal because I do worry about caregivers getting swallowed up in these networks, being micromanaged, and I also worry about what I read today in the Washington Post, as to where all of this is going.

A second question that I have, Mr. Chairman, that I certainly want to put to the panelists today is that I am still concerned about whether or not there is real choice, and whether or not the financial incentives or disincentives built into the plan may make it much more difficult for caregivers and, for that matter, consumers as well to operate within a fee-for-service framework. Since that is extremely important in parts of Minnesota, where we are not at all sure managed care is going to fit—rural, small town, inner city—I'd like to talk to you all about that as well.

Then, finally, I would like to zero in on the whole question of living within annual budgets. I think I know what your position is, and I think we have a different position, but as we think about how we are going to provide good care and also have some cost control, I think that is a thorny issue and one that I look forward to discussing with you.

My final, final point—again, I really would like to zero in on whether or not we run the danger of moving toward a very bureaucratized, conglomerate-like health care system, unless somehow the caregivers are able to set up their own networks with their own capital, without having to hang out a Prudential sign. To me, that would be an anti-design for where we want health care to go.

I thank you, Mr. Chairman.

[The prepared statement of Senator Wellstone follows:]

PREPARED STATEMENT OF SENATOR WELLSTONE

I want to thank each of our distinguished panelists for coming before us this morning, and to thank you, Mr. Chairman, for calling this hearing. The views of health caregivers on health care reform are critically important to those of us who would legislate that reform. All of us will be touched in important ways by health care reform, but the lives of health caregivers will be changed profoundly on a day to day basis by the project we undertake here.

I am pleased to note that there is fundamental agreement among those of you here before us that we must change our health care system to ensure adequate coverage for all. We don't have to think back very far to remember a time when this was not the case. I know that we owe this progress to the farsighted leadership of several of you, and I want to thank you for that contribution as well.

I am concerned by some aspects of the President's health care reform proposal, and I believe I share these concerns with many caregivers. The most consistent message I hear from doctors and

nurses and other providers in Minnesota is that they want the autonomy to make the best clinical decisions for the people they treat. They are worried about being herded into managed care plans run by and for an insurance company, whose primary goal is to turn a profit. It is one reason why the Ramsey County Medical Society, the largest medical society in Minnesota and, since it is based in the Twin Cities, the one with the most experience with health maintenance organizations, recently proposed a study of single payer systems. Some 40 percent of managed care plans are already owned by insurance companies, and the figure grows daily.

The President's proposal must assure community caregivers the funding and the independence to run their own practices, without insurance company interference and micromanagement. We must assure that there is adequate capital provided to set up the kinds of community-based and value-driven networks of caregivers that the Catholic Hospital Association has described so eloquently. Those networks, and all networks, must incorporate the voices and concerns of consumers in a central, decision-making role.

Our new world of providers must include a greater role for advanced practice nurses and other mid-level practitioners who are already so important in bringing primary care services to underserved rural areas in places like Minnesota. The President's plan goes far in recognizing the importance of these professionals. We must go farther, and give them the opportunity to work in the patient-intensive settings in which they are so effective, and not consign them to increasingly understaffed institutions, where covering an alarmingly high number of patient beds and filling out forms take priority over high quality patient care.

The proposal must make free choice of provider affordable, including the choice of a fee-for-service provider. The current proposal places financial penalties on those who would choose fee-for-service over a managed care plan, where choice of caregiver is limited. Free choice has got to remain available to middle-income and low-income Americans, not just to the wealthiest and most privileged among us.

I am introducing into the record today a statement by Dr. Cecile Rose, President of the Physicians for a National Health Program (PNHP). PNHP represents 5,500 physicians nationwide who support the single payer system proposed in my legislation, the American Health Security Act, S. 491. They suggest that the single payer system would provide patients and caregivers the greatest freedom to choose their care, while controlling costs most effectively.

PNHP has also raised questions recently about whether fee-for-service medicine will remain viable, if the majority of consumers in an area are forced, for financial reasons, into managed care plans. I believe those concerns merit consideration.

PNHP also supports, as does the President's plan, the need for annual budgets for health expenditures, and global budgets for hospitals and health care institutions. This budget discipline is key to controlling health care costs, and achieving the expansion of coverage and services that we all agree is so critical. Those of us who applaud universal coverage must face the hard facts, that it is not possible if expenditures are limitless. It is irresponsible to suggest

that we undertake the kind of major expansion of benefits the President has suggested, and hope we can leave it to market forces to control the costs.

The market cannot distribute health care services or technology fairly. We have a greater supply of high-tech diagnostic equipment in the world, but life expectancy for young males in parts of Harlem is worse than in Bangladesh. The U.S. has 10,000 mammography machines, while current demand could be met with 2,000 machines. Still, low-income women and African American women have little access to this life-saving early cancer detection device, and as a result die sooner than white women with breast cancer; and because of under-utilization, the cost of each test is twice as high as necessary.

Americans already pay more out of pocket than residents of any other nation. Somehow we have not become sufficiently cost-conscious consumers to control prices.

I invite our provider friends to focus on the needs of their patients and their nation, as they always have at their best, and take the cod liver oil of a budget as necessary to the cure, even if not always pleasant.

We have a great deal of work to do together in the coming months. I will continue to advocate that consumers deserve the best health care, based on informed, value-driven medical judgement, and on consideration for the feelings and opinions of patients. It's the kind of care I know our providers want to give. It must be based on the needs of all of the people, in underserved urban and rural areas, as well as in comfortable corners of our country. It must recognize the contributions of all of the caregivers who are willing to serve. And it cannot be based on a corporate mentality driven by profits and mergers.

I look forward to continuing to work with you on these goals, and thank you again for your testimony.

The CHAIRMAN. Thank you, Senator Wellstone.

Senator Durenberger.

OPENING STATEMENT OF SENATOR DURENBERGER

Senator DURENBERGER. Mr. Chairman, I just appreciate the chance to be here, and I appreciate the fact that in my experience, I have had now going on 16 years of speaking with these associations, and I just hope we are finally at the point where we can develop a consensus not just on the fact that something needs to be done, but where we find the common interest among all of us.

I smile when I think about it, but I must tell you—and this is for Jim Todd's benefit as well—how confused providers are. I really put this down to the fact that we are all using the same vocabulary, but we are all talking different languages, literally. But all of this stuff you're going to hear around here, talk about choice, and accountable health plans, and until we can learn to make the vocabulary mean the same thing to everybody, we are going to have some problems.

Without Minnesota, a very progressive State that Mrs. Clinton uses as an example all the time, and we've got all these terrific doctors and hospitals and all that sort of thing, last weekend, the Minnesota Medical Association went up to Duluth, and the pro-

posal was that they should initiate a study of the single-payer system, the one which my colleague advocates, and it came within two votes of passing. To me, in a State which has shown provider creativity, which is being penalized consistently by Government-run systems, the past president of the association says, "Well, I am for a single-payer system; I just don't want the Government involved in it." [Laughter.]

Senator WELLSTONE. He says more than that, but I'll keep that out.

Senator DURENBERGER. Well, with all due respect to him and to others, it is confusing out there; it is really very confusing out there, particularly for people who have committed themselves professionally to the good of all the rest of us in health care.

The CHAIRMAN. Thank you, Senator Durenberger.

Senator Hatch.

OPENING STATEMENT OF SENATOR HATCH

Senator HATCH. Thank you, Senator Kennedy.

P.J. O'Rourke said if you think health care is expensive now, wait until you see it when it is "free."

As we continue this important series of hearings, certain points will be repeatedly heard—the need for universal coverage for all Americans, the need to make institutions more efficient, the need to reduce bureaucracy; the need to reduce fraud and abuse, and the need to curtail increases in Federal spending for Medicaid and Medicare.

I want to emphasize that we must seek to preserve the vast majority of our health care system because it works well, and select carefully those aspects that need improvement. We should seek to avoid making changes for the sake of change, or for trying out new ideas that have not been appropriately tested or refined. We must recognize that there is no single simple answer although witnesses may offer many steps that might be helpful.

During these hearings, we must hope that witnesses will offer differing opinions of how they view problems and solutions of our complex systemic problems in health care. I am hopeful that at the end of these hearings, we will have a robust and useful set of views. We will then need to decide what problems need to be addressed, in what priority, and move rapidly to determine the best options for reform.

I would like to hear these witnesses' views on insurance reform as we contemplate universal insurance. I would like their reaction to my belief that reform must require individual responsibility and provide choice of care provider. I want to know why they believe Americans should not be responsible for their own health care under an individual manage. And why shouldn't Americans have real choice over what is covered under a benefit package? Shouldn't each American have the right to choose his or her own physician?

As you know, I have long championed malpractice reform as a fundamental improvement to health care. Medical liability costs are estimated to range by the AMA upward of around $25 billion plus. I think it is far higher than that if you take into consideration all the aspects of defensive medicine that come from the fear of doctors that they are going to be sued for medical liability.

The providers testifying today all confront medical liability daily. I want to have their views on my proposals for innovative arbitration and alternative dispute resolution mechanisms to keep medical liability problem out of the courtroom. Do they favor caps on noneconomic damages; limitations on single payments and limitations on attorneys' fees?

Likewise, I have urged reform of antitrust laws that unnecessarily cost us. Hospitals in Utah and other States have spent millions defending against Federal enforcement of antitrust laws—millions of dollars that could have been spent on patient care. Do the witnesses agree with the providers in Utah and elsewhere, which have repeatedly complained that Federal laws prevent them from achieving greater efficiency in giving services?

Do the witnesses share my view that the legislative relief is necessary to protect rural hospitals, which are fearful of even talking about any kind of cooperation, because Federal enforcement agencies may find an antitrust violation?

We all hear complaints about the bureaucratic complexity of providers and Government, the mountains of forms and the tangle of necessary approvals. I am sure that the witnesses will agree that agreement on common forms and electronic processing will greatly simplify administrative costs. Do they believe, however, that we can have a single form on one page for all providers?

As we look ahead, I want to keep the bureaucracy to a minimum. I hope the witnesses will let us know how different types of proposals for Government intervention would add administrative costs. If the goal is to keep health care money flowing to patient care and cut the cost of red tape, then we ought to do everything we can to do that.

Finally, the bottom line issue is controlling the costs of health care, including the soaring costs associated with Medicaid and Medicare. My view is that price controls in whatever form should be avoided at all costs, and I believe that we need to hear opinions on how to control costs without price controls.

I also want to avoid shifting Medicaid and Medicare costs to private insurance without making the necessary reforms that would curtail unnecessary cost increases. It is in the area of cost control that I think we will need the views of our very best minds in this country to determine approaches that can control costs without losing quality or imposing rationing.

So Mr. Chairman, I am happy that you are conducting these hearings and taking such a great interest in this matter, as you always have, and I appreciate your leadership in this matter. I hope these questions, though, can be answered.

The CHAIRMAN. Thank you, Senator Hatch.

Senator Simon.

OPENING STATEMENT OF SENATOR SIMON

Senator SIMON. Thank you, Mr. Chairman.

I have no opening statement. We obviously are going to be hearing a great deal in this area over the coming months, and I look forward to that.

The CHAIRMAN. Senator Kassebaum.

Senator KASSEBAUM. I have no opening statement, Mr. Chairman.

The CHAIRMAN. Thank you.

The CHAIRMAN. The first panel is composed of representatives of the two leading hospital associations of the United States. Dick Davidson is president of the American Hospital Association. Many of us have worked closely with him over the years. He is widely respected by Members of Congress on both sides of the aisle.

I think you know, Mr. Davidson, we have a very effective association in Massachusetts; Steve Hagerty chairs that association, and they have been enormously constructive and positive and helpful to all of us in terms of understanding the interests of the hospitals.

We are delighted as well to welcome Sister Maryanna Coyle, who is the president of the Sisters of Charity of Cincinnati and is responsible for the operation of the health care system that includes 20 hospitals as well as other health facilities. She is here today as chairperson of the board of trustees of the Catholic Health Association of the United States. The Catholic Health Association represents more than 1,200 Catholic health facilities nationwide and has been in the forefront of the movement to assure health care access for all. As she knows, Sister Caritas of Mercy Hospital in Springfield is one of the very dynamic spokespersons also on the issue of health care, and I know she shares my high regard for her. We are delighted to have her here today.

Mr. Davidson, as you can probably tell at the outset, there is not a uniform opinion about what we ought to be doing.

Just before you proceed, I see my friend and colleague Harris Wofford. Did you have any opening comment?

Senator WOFFORD. No, Mr. Chairman. Thank you.

Mr. CHAIRMAN. Before we begin I have a statements from Senators Mikulski and Dodd.

The prepared statements of Senators Mikulski and Dodd follow:]

PREPARED STATEMENT OF SENATOR MIKULSKI

Madame Secretary, it is an honor to welcome you back to this Committee. In your short tenure at HHS you have already become a forceful advocate for prevention. Your leadership on childhood immunization is to be commended. And that leadership is reflected as well in the President's health care plan. I would also like to extend a warm welcome to our other witnesses testifying today.

I am very pleased to see that the President's plan builds on the provision of prevention services—especially for women and children where it has been so neglected in our health care system in the past.

In fact, I believe that this is the first President to not only advocate a comprehensive core benefit package for everyone but to advocate access that is based on prevention and screening.

Health promotion and disease prevention are perhaps our best opportunity to reduce the ever-increasing portion of our resources that we spend to treat diseases. Medical care alone won't work. The best research alone won't work. Caring and sensitive health care providers alone won't work.

We need all of that and we need more. We need a basic benefit package that provides—free of charge—key preventive health bene-

fits. We need to create a culture of personal responsibility for healthy behavior. And we need a strong public health service that provides education, outreach and services for people in their communities.

There is perhaps no greater challenge we face than stopping disease and illness before it starts. Saving lives has long been a core mission of this Committee and of the public health service. The economics of prevention—as we have found out from Healthy People 2000—is not only good for our health—it is good for our wallet.

Think of the lives and money we could save if we turned our health care system upside down and started preventing disease instead of waiting until people got sick. The yearly cost of treating alcohol and drug abuse is at least $16 billion. Smoking related illness cost $65 billion a year. Preventable injury alone costs over $100 billion a year, cancer over $70 billion and cardiovascular disease $135 billion.

We need to change the mind set in this country. And this pla will begin to help us do that.

Madame Secretary, last year one-third of American women di not get any basic preventive service. No mammogram. No pelvic exam or pap test. No physical or breast examination.

Breast cancer, cervical cancer and other gynecological cancers diseases can be prevented or detected early and treated successfully. Yet by and large, these women were not referred by their physician for screening services.

I am very pleased that the President's plan provides for these services, but I have some serious concerns about the frequency for which they will be provided.

The President's plan seems to call for a screening mammogram for women every other year after the age of 50—even though the American Cancer Society and the National Cancer Institute recommend annual screening after the age of 50 and screening every other year for women over the age of 40. The Plan also limits annual pap tests to once every three years if a woman tests negative for three years in a row.

I also have some concern that money will be cut—over $90 million—from the public health service programs to offset the cost of the new plan before the new plan is even operational.

Mr. Chairman, the public health services this Committee legislates are vital to our states, our local communities and to the people they serve. They create the infrastructure at the community level that get people to the services they need. They monitor access to care and assure services for people who otherwise do not have access to appropriate care. They promote health.

I know we share common goals in reforming our health care system Madame Secretary: first, that the new system make health care accessible to everyone: second, that it control costs without cutting quality: third, that it make health care reliable and portable, and forth, that it eliminate the hassle for families, business and providers.

I look forward to your testimony and to working with you in getting the best health care reform legislation enacted into law.

PREPARED STATEMENT OF SENATOR DODD

I want to thank the Chair for holding this morning's hearing. In my view, it's critical that we hear the views of people on the front lines of medicine early in the discussion of health care reform.

IMPORTANCE OF PROVIDERS' VIEWS

It makes sense that our first two hearings—following Mrs. Clinton's overview—would focus on patients and providers, the groups most directly affected by our current system and proposed reforms.

PROVIDERS' UNIQUE VIEW TO WHAT'S WRONG

Our providers have a unique view of what's wrong with our health care system. Our doctors and nurses know what it means when a patient's care cannot be continued because of the loss of insurance. They know what it means when necessary procedures are not covered by a patient's insurance plan. Patients end up in their offices who cannot afford to pay the out of pocket costs for medicine. And our hospitals know the human and economic cost of treating the uninsured in emergency rooms.

Our providers face frustration in the system every day. They spend time doing paper work when they could be with patients. They are forced to practice defensive medicine, yet are blamed for ordering too many tests. If they choose to practice in an underserved area they have limited access to information and technology and face demand for their services that outstrips their time.

MAINTAIN QUALITY CARE

While providers can tell us much about what's wrong, they offer an important view on proposed changes to the health care system. We need to hear from providers so that as we move to fix what's wrong, we do not inadvertently disrupt or destroy what's right in our health care system. And our Nation's providers are a major part of what's right. Indeed, the Nation is focused on the issue of health care reform largely because we want all Americans to have access to the high quality care that now exists only for some.

Mrs. Clinton emphasized to this committee last week that "we want to preserve and strengthen the high quality of medical care that is a trademark of our Nation—our unrivaled doctors, nurses, hospitals, and sophisticated technology." She and every member of this committee agree that the health care in this country is the envy of the world. I look forward to hearing from the provider groups this morning and expect to maintain an ongoing dialog as the debate continues. Our nurses, hospitals, primary care doctors, and specialists are the backbone of our health care system, and therefore critical to the discussion.

Mr. CHAIRMAN. Mr. Davidson, please proceed.

STATEMENTS OF DICK DAVIDSON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC, AND SISTER MARYANNA COYLE, PRESIDENT, SISTERS OF CHARITY OF CINCINNATI, AND CHAIRPERSON, BOARD OF TRUSTEES, CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, WASHINGTON, DC

Mr. DAVIDSON. Thank you, Mr. Chairman and good morning.

I am Dick Davidson, president of the American Hospital Association. We are kind of the umbrella group of all of the hospitals in America, some 5,000 member institutions across the country, representing virtually all of the interest—religious, not-for-profit, investor-owned, governmental institutions. You name them, and they are an integral part of our association. So when we speak here before you today, we are speaking in the interests of all of the hospitals in America.

I want to say at the outset that the American Hospital Association salutes President Clinton and the First Lady for nurturing the current health care reform debate. We think it is time; we think we will all come to some place where we will reach some agreement. America is ready for this, and providers are ready for it. The status quo is no longer sustainable, and we have got to move to a better place.

We commend you, Mr. Chairman. I know you must feel excited about what is going on, after 25 years of being a pioneer in this area. It seems that timing is everything, and the time is now.

What I would like to do this morning is to talk a little bit about some of the issues of the President's proposal and get to some details later. There are three things.

First, the President's plan has a lot of common ground for hospitals in this country, because we stand for a variety of things and feel strongly about them. No. 1, we feel that our job is to help improve the health of the population. Second, we are for universal access to health insurance. We think that is a moral imperative, and it is time to move there. Third, we think we need a more integrated delivery system. The current one does not work effectively, and we must change it.

In addition, we think there needs to be economic discipline in the system in order to deal with cost control, and we think there must be much greater public accountability. We need to deal with the problems of professional liability and to move on into other areas of antitrust, and we thank Senator Metzenbaum for his leadership. We have made an important first step, and we thank you publicly, Senator, for your leadership in that area.

Second, universal access and delivery system reform are our two highest priorities. We do not believe that access to care in America should be expanded into this delivery system; if we are going to give more Americans the opportunity to get care, it should be into a new delivery system, and we are prepared to talk about that.

Finally, with any comprehensive health care reform proposal, there are going to be certain things that people have some concern about, and we have some concerns with the Clinton plan and will share our observations about them and whether we can offer some proposals to clear up the rough spots.

Let me first accentuate the positive—how the President's plan fits our vision. We stand squarely behind the President's insistence on achieving universal access to insurance through the workplace. It is the most practical way to achieve the objective; we think it may be the only way to get there in the near term. The status quo is not sustainable, and that is why we support that notion.

The President's plan also begins to create a new environment for health care delivery for hospitals, for doctors and other providers, in essence bringing us together to cooperate. The accountable health plans he proposes are "kissing cousins" to the AHA's notion of community care networks. We would hope that they would actually become "twins" in that we think it is essential that we have community-based organizations working together. So we think we can build on the President's proposal to bring about more community-based collaboration among doctors and hospitals, and we can talk about that.

Our job, in our view, is that we should do what we do best, and that is keeping people healthy and taking care of the sick and injured. That is the nature of the business we are in, community by community, across America.

Next, the problems and our proposed solutions. First, Medicare program spending growth is arbitrarily capped so that about $124 billion is squeezed out by the year 2000. These changes are not intended to fix what is wrong with the Medicare program. These changes in payments to hospitals and doctors are made solely for the purpose of financing additional benefits. And of course we agree with the idea of providing expanded benefits, but we strongly object to financing them out of further payment cuts to hospitals, which in essence provide a substantial portion of care to the Nation's elderly. We do not think that system can work the way it is structured at this point.

This, coupled with the fact that services for the Medicare population continue to be paid for in the President's plan on a per-admission or per-visit basis, really amounts in our view to business as usual, and we have got to change that.

Medicare's payment system is broken. We can tinker on the edges of payment forever and never get it straight and never get it fixed. We have got to change that, and in this reform proposal, we have got to look at ways that we can move the elderly of the Nation into a new delivery system. We think that that is absolutely essential.

Also, the overall plan reduces the deficit by $91 billion. We just went through a budget debate and budget crisis where we ultimately ended up using payment to hospitals and doctors to reduce the deficit by some $56 billion. We cannot imagine that we are going to sustain another $91 billion deficit reduction strategy in the health care field, and we think that those funds ought to be used to expand the benefits to senior citizens, and those funds ought to be set aside to assure that we don't have to have arbitrary cutbacks in the future; that health care reform should not be the vehicle for deficit reduction. We are trying to solve a very serious social and economic problem in this country. So we are very concerned about that.

In addition, the way we treat Medicare patients today if we are going to move into the future and have two kinds of delivery systems—one for people outside Medicare and one for people in Medicare. Forty percent of the revenues that flow through hospitals and 30 percent of the patients that we treat are senior citizens. We cannot reform the delivery system if in fact almost half of the folks that we take care of are on a different kind of payment arrangement. So we have got to change that.

The Medicare spending cap is just one kind of cap that is being looked at. But there is also another cap being looked at, and that is another way to find how to put a cap on private sector spending. The administration proposes a formulistic strategy to putting a cap on private spending through insurance premium caps, and it is a formulistic approach which defies some logic. We think it is important to begin to look at how we have targets to look at in the future, but to say that we are going to have arbitrary caps and kind of put the system on "cruise control" and take our hands off the wheel is something that concerns us very much.

Instead, in our view, any attempt to limit spending on the private side must include a process to match personal health needs with available resources in an open and public way. We have got to have public debate as we expand benefits, so we are sure we don't make more promises than we can deliver. We think the President's proposal for an independent commission provides the public opportunity to have those kinds of debates along with the U.S. Senate and the House of Representatives, and we think that is an essential way to do that.

So we are unalterably opposed to the kinds of price controls that are described in the President's proposal, but we are certainly willing to talk about some way to establish reasonable growth and oversight in health care expenditures for the United States.

Health system costs can only be controlled if we change the way we operate at the community level. I just want to repeat that. To us, that is the most essential thing. We must change the health delivery system community by community across America. The job of the Federal Government is to provide incentives to make that happen. There is no cookie cutter that we can provide from Washington to make these things happen. But there are incentives, and we think the President's plan provides incentives. They employ capitated payments to groups of providers. From our perspective, this is absolutely key to cost control because it is going to encourage hospitals and doctors and other providers to begin to work together in a way you have not seen them work together in the past. We think that is the key to success for the future.

For such collaborative effort to be successful, we see the need for some change in the way the President's accountable health plans are put together. There needs to be a lot more detail. We think the President is absolutely on the right track. We think there must be better safeguards to prevent these plans from being simply fly-by-night insurance mechanisms run out of tall buildings in big cities, with computers and discounted contracts. In our view, that is not health care reform. We think we have got to reform the system community by community and let communities have responsibility for oversight.

So we propose minimum Federal guidelines for health plans to ensure that they are locally governed and accountable to the people they serve. We need to turn the health care delivery system back to the people. To us, that is the essential way to reform this system.

In closing, these are the key issues for America's hospitals. We have many other ideas for change that will help make the pieces of this reform plan better and fit together, and we are willing to support them and support them vigorously. We pledge to you, Mr. Chairman and members of this committee, a constructive hospital effort to achieve the key principles outlined in the President's plan and reach our shared goal of better health care for all Americans. We think the time is now.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Davidson follows:]

PREPARED STATEMENT OF DICK DAVIDSON

Good morning. I am Dick Davidson, President of the American Hospital Association, representing 5,000 hospitals and health care organizations across America. It is a pleasure to be here this morning in the cause of moving health care reform forward. Senator Kennedy and other members of this committee have been true pioneers in the effort to extend and improve health coverage for the nation, and I know you share the American Hospital Association's excitement about the real opportunity for achieving that goal that the current environment provides us.

AHA salutes President Clinton and the First Lady for their significant work in nurturing the current reform climate. America's hospitals, through AHA, have worked for more than two years to shape our own blueprint for health care reform: we are very pleased that the President's plan shares many of our building blocks. In a nutshell, AHA's reform objectives include:

1. Universal access in a reasonable time period financed in a pluralistic manner;
2. Redeveloping health care delivery into an integrated and coordinated system able to address the needs of the population;
3. Economic discipline based on clear incentives rather than micromanagement;
4. Balancing promised benefits with adequate financing;
5. Public accountability for the clinical effectiveness and economic efficiency of health plans;
6. Antitrust and malpractice reform.

You will notice that "universal access" is at the top of the list. We share the President's belief that any reform plan must move us as quickly as possible to health coverage for all. This is a non-negotiable item for us, not only because it is the morally right thing to do, but also because without universal coverage health care reform simply doesn't work—without it, you will still have a system with providers continuing to shift costs from the uninsured to the privately insured, undermining our goal of moderating rising health costs.

The other basic building block we share with the Clinton proposal is its boldness in calling for a fundamentally restructured health care delivery system. In the Clinton proposal, health plans would offer a guaranteed national benefit package to consumers, without regard to pre-existing conditions. The plans would receive a fixed, per-person annual payment, providing the financial resources for preventive care that our current system so sorely lacks.

The Clinton proposal's "health plans" provide the structure to accommodate AHA's own approach to restructuring the delivery system through community care networks—cooperating groups of local providers paid on a capitated, or per-person, basis. This approach provides the economic incentives for providers to work together, eliminating expensive duplication of services and technology, and for establishing a seamless system of care that works better for patients.

We also like the fact that the Clinton proposal establishes a framework for a national independent commission that would interpret and update the guaranteed national benefit package to be offered to consumers. And, we endorse the proposal's movement toward more clearly spelling out anti-trust guidelines. The current anti-trust climate is murky. Hospitals that want to merge or share technology are some-

times discouraged from doing so out of fear of running afoul of the Justice Department and regulators. This chilling effect undermines our shared goal of achieving greater efficiency in health care delivery.

While we have more agreement than disagreement with the Clinton proposal—more common ground than battleground—we would like to share with you our areas of significant concern, and offer our view of how these areas can be improved.

First, under the Clinton proposal Medicare spending growth is capped so that $124 billion is squeezed out of the program by the year 2000. These changes are not intended to fix what's wrong with the Medicare program. They will fund prescription drug and long-term care benefits for the elderly. We are supportive of these benefits, but we can't support underpaying hospitals in order to finance them.

The solution? The Clinton plan calls for using reform savings and taxes to reduce the deficit by $91 billion. We believe those savings should be left in the health care reform effort where they can reduce the need for arbitrary cuts. First of all, providing universal access to health coverage is going to increase health spending. This is not the time to be bleeding resources from the system. Second, the process of reconfiguring hospitals and other provider services also takes financial resources. We know from experience that laying out a solid plan for merging services between two hospitals, or between a hospital and physician group, can take a year or more. Hospitals must have the resources that allow them to do this; they won't have them in a too-constrained financial environment.

The infrastructure investments we all endorse in order to reduce administrative costs—electronic billing, computerized patient records, new information systems—also require front-end dollars before they can be put in place. Our ability to get beyond the traditional hospital acute care role that will be necessary under reform is also jeopardized by excessive spending reductions. For example, consumer education, wellness, and outreach programs—not funded by the current system—are among the most vulnerable programs when finances are squeezed.

A similar disconnect of actual needs from resources happens on the private side in the Clinton proposal, where spending growth is capped by tying it to the Consumer Price Index (CPI). But the CPI has no real link to the actual costs of providing care; health care has its own set of input costs that aren't reflected in the CPI—labor costs that are driven up by health care personnel shortages and the steeply rising cost of new medical technology, for example.

We agree on the need to slow health spending growth. But to try to do it through a rigid formula amounts to putting the system on cruise control, taking one's hands off the steering wheel, and hoping for the best. That is not a responsible way to navigate the uncharted territory of health reform. Why? Because it doesn't allow us to adjust course to accommodate unforeseen circumstances. The slowness of the economy in coming out of the recession; previously unknown crises such as the AIDs epidemic—all caution that we keep our hands firmly on the steering wheel. And the way we do that is to match health needs with available resources in an on-going, open and public way. In our view, that should be the job of the independent national commission.

We also have concerns about the structure of the Clinton health plans. While they have shared characteristics with our vision of integrating care through community care networks, they are by no means identical. The health plans must have a better-defined role set out at the national level, and more accountability built in at the local level. We have real concerns that as currently defined they could harbor fly-by-night insurance schemes. The way to address these concerns is to make sure health plans are under local governance, are targeted toward meeting local needs, and have a local accountability mechanism.

So yes, there is work to be done in examining these and other areas of concern, such as the size of health alliances. We need to work together to identify options and compromises. But it's not an impossible job. We have been given a strong start by the President and the First Lady in putting forth a serious reform initiative. Much work has already been done in Congress as well, including efforts by this committee. And a spirit of bi-partisanship is emerging.

For those of us who see a broken health care system and want to fix it, it's a truly exciting time—even an historic time—for health policymakers and providers. We sense a rare opportunity, an opportunity that may not come again for a long time, to reshape our health care system to make it work better for all of us.

Hospitals pledge to play a constructive role in that process. To work hard to support reform elements we believe build the right foundation, and to find agreement in those areas we now feel are not solidly grounded. As the American Hospital Association serves in that role, we don't see ourselves as advocates for the President's plan, or the Conservative Democratic plan, or the Senate Republican plan; for busi-

ness or for labor. We see ourselves as advocates for the workable, the truly better—in short, for good public policy.

Legislation that captures these qualities is likely to be drawn from positions all along the political spectrum. As politicians skilled in the art of compromise, I know you recognize that truth as well. The American Hospital Association looks forward to working with you to reach our shared goal of better health care for all Americans.

The CHAIRMAN. Sister Coyle.

Sister COYLE. Good morning, Mr. Chairman and members of this committee. My name is Sister Maryanna Coyle, and I am here as chairperson of the board of trustees of the Catholic Health Association of the United States, CHA, which represents over 900 health care facilities nationwide.

As president of the Sisters of Charity, I am also a sponsor of our health care system, which is the 5th largest Catholic system in our country, with facilities in Ohio, Kentucky, Colorado, New Mexico, and Nebraska.

The CHA recognizes and commends you, Mr. Chairman, for the untiring dedication that you have shown toward the cause of universal health care coverage during the past 25 years. Like the President, CHA believes that the debate about health care reform is essentially a debate about values. We believe that, first, health care is a service, not a commodity; second, human dignity requires universal, comprehensive coverage; third, public policy must serve the common good; fourth, growth in health care spending must be controlled; fifth, the well and the wealthy have a responsibility to care for the poor and the sick; and sixth, a reformed health care system must promote simplicity.

CHA is encouraged by the fact that the President's proposal is based on a similar set of principles. We believe that nothing short of comprehensive health care reform can fix our broken system. To that end, CHA has designed a proposal for systemic health care reform.

We are convinced that if Congress fails to act forcefully, comprehensively, and soon, matters will only get worse. Incremental approaches are no longer an option.

Mr. Chairman, we call on you and your committee to hold fast to several components in the President's health care proposal. Hold fast to universal coverage and the speed with which it is accomplished under the Clinton proposal. It is the linchpin of reform.

Hold fast to a substantial uniform benefit package. Avoid a basic package that becomes a floor for the middle class, but a ceiling for the poor.

Hold fast to the many protections for low-income populations that are incorporated, including the incorporation of Medicaid funds into health alliances.

Hold fast to provisions for uninterrupted coverage of consumers regardless of employment status—a focus on keeping people healthy.

Hold fast to the high degree of consumer choice among health plans created by the use of regional health alliances.

Hold fast to overall expenditure controls. CHA is on record in favor of a global budget.

Hold fast to the financing mechanism in the Clinton proposal that asks everyone to share the burden. Do not retreat on the employer mandate.

Finally, hold fast to the high cut-offs for firms that use health alliances, to avoid exacerbating the fragmentation and cost-shifting which is the reality of our current system.

While we all urge you to hold fast to these components, I want to share with you five ways in which the CHA believes that the President's proposal must be strengthened.

First, it needs a much sharper focus on delivery system reform. This can be achieved by a) merging the insurance and delivery functions in the form of integrated networks that provide a coordinated continuum of care for an enrolled population; b) incorporating Medicare into the overall reform system through a scheduled transition process; c) fully integrating long-term care with acute care under a specified timetable if we are to have truly a continuum of care, and d) creating a more realistic timetable for reducing the rate of growth in both public and private health care spending.

The President's proposal indicates that reductions may not be too much, but they certainly are too fast for an effective, quality system.

Our second recommendation for strengthening the Clinton proposal is to employ a more effective process for setting the global budget by incorporating critical information about population needs and local system efficiencies over time. This is a bottom-up, top-down, as opposed to top-down approach.

Third, CHA strongly opposes, on both moral and political grounds, the inclusion of abortions in the guaranteed national benefit package. We are hopeful that Congress will keep health care reform and legal abortions as separate and distinct issues.

Fourth, CHA firmly supports the inclusion of a strong conscience clause provision for individuals, institutions, and employers in health care reform legislation.

Fifth, it is quite possible that commercial influences will overwhelm the professional ethos in American medicine. In this regard, two questions arise. How will patients fare when the treatment that they need could make their provider less competitive and less profitable? Second, will health plans owned by commercial interests beholden to distant shareholders abandon communities when their profits are squeezed?

In conclusion, Mr. Chairman, our success in reforming the American health care system will be measured by the responsive given to the following question: Did we produce a reformed health care system that better meets the needs of individuals, families, and communities?

Thank you.

[The prepared statement of Sister Coyle follows:]

PREPARED STATEMENT OF SISTER MARYANNA COYLE

Good morning, Mr. Chairman and members of the Committee. My name is Sister Maryanna Coyle. I am Chairperson of the Board of Trustees of the Catholic Health Association of the United States (CHA). The Catholic Health Association represents more than 1,200 healthcare facilities and organizations that make up the nation's largest group of not-for-profit healthcare institutions under a single sponsor.

I am also President of the Sisters of Charity of Cincinnati which sponsors the Sisters of Charity Health Care Systems, Inc. Our twenty hospitals, four long-term care facilities and five retirement communities in five states constitute the fifth largest Catholic healthcare system in the United States.

Mr. Chairman, it is an honor to appear before your committee as Congress begins to determine how—not whether—to reform our nation's healthcare system. At the outset of our testimony we want to recognize and commend you for the dedication and perseverance you have shown to the cause of universal healthcare coverage during the past twenty-five years. You had the courage and tenacity to keep the beacon lit even when the prospects for universal coverage seemed hopeless.

CHA shares your belief, and President Clinton's, that the goal of universal healthcare coverage is and must remain the one non-negotiable item throughout the coming debate on healthcare reform. It is, Mr. Chairman, the linchpin of reform. Since 1986, CHA has been a consistent advocate for universal coverage in a redesigned healthcare system. In our testimony today, we will, first, state our basic agreement with many of the components of President Clinton's proposal and indicate that we believe his proposal is headed in essentially the right direction. Second, we will make a number of recommendations that we believe are necessary to strengthen the proposal. Finally, we will pledge ourselves to work with the White House and the Congress to do everything we can to make meaningful healthcare reform a reality in 1994.

A. THE NEED FOR VALUES-BASED REFORM

Two years ago the Catholic Health Association developed its own proposal for healthcare reform.[1] This comprehensive plan describes our vision for a healthy America. You can imagine how pleased we were to hear Mrs. Clinton cite our plan as a model for the Administration's own reform proposal in her testimony before this and other committees last week.

Like the President, we believe that healthcare reform is essentially a debate about values. Accordingly, our proposal is anchored in the following set of core values. We believe that:

- healthcare is an essential social good, a service to persons in need which should never be reduced to a mere commodity exchanged for profit;
- human dignity requires that all persons be guaranteed a right to a uniform, comprehensive package of healthcare services;
- our nation's excessive focus on individual and institutional self-interest must be balanced by a recognition of the common good;
- our healthcare system must be reorganized so that it can better manage healthcare resources and better control the growth in healthcare spending;
- we must re-establish the principle that the well and the wealthy have a responsibility to care for the poor and the sick; and,
- a reformed healthcare system must promote simplicity by placing responsibility at the most appropriate levels of organization.

CHA is encouraged by the fact that President Clinton's reform proposal is based on a similar set of principles. As the President's reform proposal notes, these values "reflect fundamental national beliefs about community, equality, justice and liberty" and they anchor healthcare reform in our nation's "shared moral traditions."

B. THE NEED FOR SYSTEMIC HEALTHCARE REFORM

Today, millions of working Americans, their families, and others cannot afford or otherwise obtain healthcare insurance, and are often excluded from the benefits of our nation's healthcare system. Hundreds of thousands go without needed care or become impoverished when they have to pay their medical bills. And large numbers die prematurely for lack of care. Paradoxically, all of this is happening at a time when national healthcare expenditures are escalating rapidly, seemingly without control, and are consuming increasing portions of the nation's wealth. These problems have been exacerbated by the abandonment of community rating in private health insurance and employers' growing resistance to cost shifting. Together these developments are undermining our nation's voluntary social safety net in healthcare and are making it more difficult for many of our non-for-profit healthcare institutions to meet their historic missions of community service.

Meanwhile, the healthcare delivery system is fragmented and lacks economic discipline. It is increasingly burdened by a broad range of private and public rules on prices, volume, and methods of treatment that make American healthcare providers among the most regulated in the world.

Mr. Chairman, we have reached the point in healthcare when one thing is certain: if Congress fails to act forcefully, comprehensively, and soon, things will only get

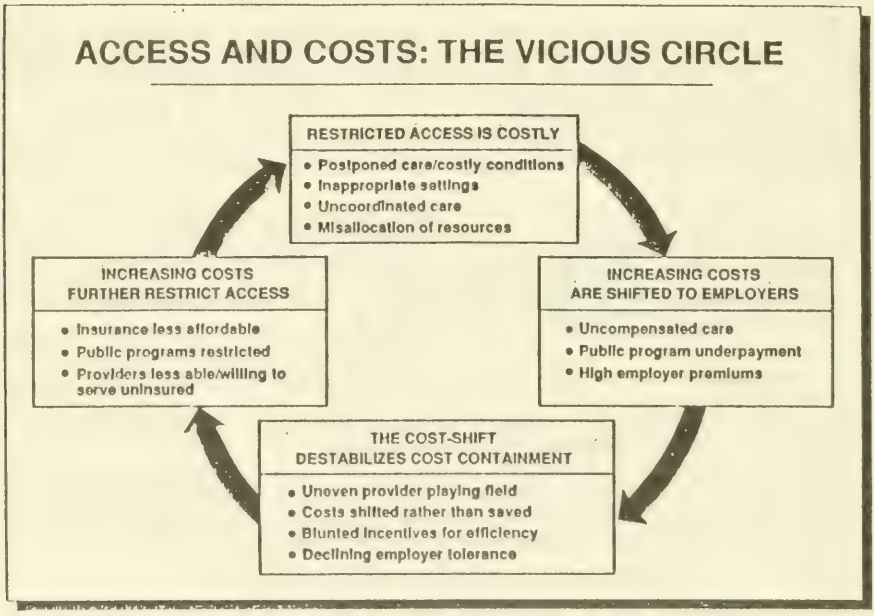
[1] Setting Relationships Right: A Proposal For Systemic Health care Reform, The Catholic Health Association of the United States.

worse. We no longer have the luxury of ignoring the problem and hoping that, somehow, someday, it will simply fix itself. Similarly, partial or incremental approaches are no longer an option. The underlying problems are systemic in character and, as the President has recognized, can only be addressed through comprehensive change.

C. COMPONENTS OF THE CLINTON PROPOSAL SUPPORTED BY CHA

Now let me turn to the specifics of the President's proposal. Mr. Chairman and members of the committee, we call on you to hold fast to several critical components of the President's approach to reform.

1. We urge you to hold fast to universal coverage. The Clinton proposal calls for coverage of all our citizens by January 1, 1998. For both moral and pragmatic reasons, we ask you not to compromise either on the principle of universal coverage or the speed with which it is accomplished under the Clinton proposal. The moral reasons should be clear to everyone. We should no longer tolerate being the only Western industrialized nation that leaves millions of people without healthcare coverage. Research has shown repeatedly that the 37 million uninsured in this nation are more likely to forego or postpone care than their insured counterparts.



The pragmatic reasons for universal coverage are equally compelling. Anything less than universal coverage creates a vicious circle whereby the uninsured are more likely to receive care in costly settings like the emergency room and for conditions that have grown more severe with time. The resulting high cost of this care is then shifted to employers who in turn find insurance coverage for their workers increasingly unaffordable. We must break this vicious circle if there is to be any hope of controlling health expenditures in this nation.

2. We urge you to hold fast to the guaranteed national benefit package included in the Clinton proposal. Again there are both moral and pragmatic reasons for this. Morally, we should avoid crafting a "basic" package that becomes a floor for the middle class and ceiling for the poor. We believe that the best strategy to defend the interests of the poor is to create a system that ties their fate to that of the average person. Such a system has the powerful potential of drawing our society together rather than dividing it along economic or class lines. Our most successful social programs, Social Security and Medicare, include all Americans, rich, middle class and poor. Pragmatically, a pared down uniform benefit package would only

perpetuate the cost shifting and insurance risk segmentation that are tearing our current healthcare system apart.

3. We urge you to hold fast to the many protections for low income populations in this proposal. Most important is the incorporation of Medicaid funds into the Health Alliance along with most other forms of financing. No longer would the poor be treated as a separate class of citizens when it comes to financing for the new system, because premium payments to plans for former Medicaid recipients, other low income populations, and everybody else in the Health Alliances will be indistinguishable. The fate of the poor will be tied to the fate of the middle class. This is the right and moral thing to do. It will also contribute substantially to system stability over time because it ends the cost shift from Medicaid to the private sector, reduces the exposure of Medicaid financing as a singular "easy" target for budget cutting, and eliminates many of the financial disincentives to serve the poor. Finally, it would eliminate the current disincentive to leave welfare since the poor would no longer face the prospect of losing their health insurance when they take a job.

4. We urge you to hold fast to provisions for continuous, uninterrupted coverage of consumers. As in our own proposal, President Clinton has largely ended the link between employment and health insurance coverage. Both the employed and the non-employed under his plan can select from among any certified health plan in their community. No longer would a person's choice be restricted to the one or two health plans selected by his or her employer, and when a person changes jobs or becomes temporarily unemployed, he or she can stay with the same health plan and the same family physician. This is important both because it is the humane and dignified thing to, and because a continuous, uninterrupted relationship with one's physician is critical to the goal of keeping people healthy.

5. We urge you to hold fast to the high degree of consumer choice embodied in the President's plan. The main reason there is so much choice in his plan is not because of the so-called "fee-for-service" option, but because the link between employment and health care coverage has been severed. Even without the fee-for-service option, a family could select any certified plan in the community, which means they could go to the health plan that has their family physician as a practitioner. This is simply not possible for many working families today who often find they must abandon their family physician as they change jobs.

6. We urge you to hold fast to overall expenditure control in the President's proposal. CHA has long been on record in favor of a global budget. Morally, this is a question of responsible stewardship. As a nation we can no longer allow unpredictable and uncontrollable health expenditures increase in a way that squeezes out other important social needs like education, social services and public health, enlarges the deficit, and makes many U.S. companies less competitive. Pragmatically, we all know that the rate of increase in healthcare spending is unsustainable and there is no guarantee that "managed competition" by itself will work without an expenditure "backstop."

7. We urge you to hold fast to the more equitable financing inherent in the Clinton proposal. Everyone is asked to share the burden in this plan and "free riders" are no longer allowed to shift their health care costs to those who have been willing to pay. The employer mandate is critical to this approach because it ends the destabilizing cost shift from one employer to the next, and because it reinforces the notion that we are all in this together. Please don't retreat on the employer mandate.

8. Finally, we urge you to hold fast to the high cutoff for firms that must use the Health Alliance in the President's plan. As you know, all firms with fewer than 5,000 employees would pay standardized premiums to the Health Alliance which would then negotiate with health plans on behalf of all workers. To lower this threshold and allow substantial numbers of employers to continue negotiating separately with health plans outside the Health Alliance would be a serious mistake.

We carefully considered letting employers have this option when we developed our own reform proposal, but we found that it would have the potential to:

- perpetuate the cost shift as different premium levels are negotiated inside and outside the health alliance;
- constrain consumer choice as families might be limited to the health plans selected by their employer rather than all health plans in a community;
- disrupt continuous relationships with physicians as consumers are forced to change plans whenever their employment status changes;
- reinforce risk segmentation as health plans could continue to find ways (even with insurance market reforms) to selectively market to firms with younger, healthier populations;

- segregate lower and higher income populations as the health—alliances would serve predominately small, low wage firms and the former Medicaid populations; and
- increase administrative costs associated with continued employer involvement, multiple health plan contracts, and turnover among plans by consumers.

Please don't retreat on the high employer threshold for participation in the Health Alliances.

D. STRENGTHENING THE CLINTON PROPOSAL

Allow me to share with you five ways in which the Catholic Health Association believes the Clinton proposal must be strengthened.

1. Delivery Reform

First, the proposal needs a much sharper focus on reform of the healthcare delivery system. As it now stands, the proposal deals extensively with coverage, access, financing, and expenditure control, but says very little about how the healthcare delivery system can and should be reoriented to achieve both lower costs and clinically effective healthcare.

CHA's healthcare reform proposal starts with delivery reform as the way to make healthcare better coordinated, less costly, and more responsive to needs of people and communities. At the heart of our plan is the person-centered, community-based Integrated Delivery Network or IDN. The IDN is a set of providers organized to assume financial risk for a full continuum of healthcare services. Providers are linked together through a series of contractual or ownership arrangements. These networks receive a risk-adjusted, capitated payment and are held accountable for improving or maintaining the health status of their enrolled populations. In the CHA vision, consumers participate in network decision-making and choose among competing networks based on quality and service.

We believe that the kind of delivery reform embodied in these networks is essential for true, long term cost control in a reformed system. This is because the incentives in a capitated network are realigned to encourage primary and preventive care, less unnecessary care, better coordinated care, services in less costly settings, more appropriate capacity levels, and a more rational use of high technology services. Without delivery reform, however, insurers will be encouraged to rely on a la carte discounting, rate setting, formula-driven utilization controls, and micromanagement of providers in order to get the "quick" savings they need to live within premium caps. Some of these devices may, in fact, be appropriate. But to rely on them solely will be a mistake. We believe that the insurance function should be merged with the delivery function in the form of integrated networks and that the focus should be on more efficient methods of organizing care, not simply clamping down on payments and utilization.

I want to emphasize that the Clinton proposal does include new incentives for delivery reform. As you know, consumers in the President's proposal are given financial incentives to select cost-effective health plans, and the plans will often have to organize themselves to operate within annual premium limits. The President has also stressed primary and preventive care in his guaranteed national benefit package.

But there are also several elements of the Clinton proposal that will impede or hinder delivery reform. First, there is little emphasis on the need for clinical and financial integration of care in the form of community-based, person-centered networks. Rather, the proposal assumes and even encourages significant reliance on insurance companies to form and administer plans. This, in itself, is not a problem as long as the insurers act as partners with providers to create truly integrated community-based networks. It does become a problem, however, if insurers act as distant regulators who seek savings simply through discounts and formula-driven utilization controls, as many do today. This kind of arrangement may bring "quick" savings to the system and substantial profits for insurers, but it will not result in better coordinated or more efficient care. Nor will it ensure accountability to local communities.

Another impediment to delivery reform is that Medicare is left outside the new financing arrangements. While the Health Alliances may encourage more integrated systems of care through annual per person payments, Medicare will perpetuate the opposite incentive by paying providers on a procedure-by-procedure basis. Thus providers will continue to face the mixed and counterproductive financial incentives that plague our current system. We can understand why Medicare may not be immediately folded into the Health Alliances, but we urge you to consider a fixed

schedule and transition plan for bringing in Medicare to ensure consistent, stable incentives.

Another impediment to delivery reform is the failure of the President's plan to fully integrate long term care with acute care. We support the President in his expansion of long term care services to the disabled and elderly, but once again, sustainable cost savings will occur only if integrated networks can manage the full continuum of healthcare services, thereby allowing them to make patient-specific decisions about the most appropriate, most humane, and least costly patient care settings. Admittedly, local healthcare systems are not yet prepared to accept capitated payments for the full array of acute and long term care services, but reform should move the system in that direction through a target date and transition plan. Otherwise, we will perpetuate an artificial and costly bifurcation in what should be a seamless continuum of care for people in all stages of life.

Finally, delivery reform will be hindered because expenditures in the Clinton proposal are compressed unevenly and unrealistically fast. As I said earlier, CHA fully supports the need to bring both private and public healthcare costs under control through a global budget. But the current draft of the Clinton proposal calls for a faster compression for Medicare and Medicaid. This will result in greater cost shifting between the public and the private sector, and could ultimately lead to severe access problems for the elderly.

More importantly, total spending is brought down at an implausibly rapid rate that may well encourage "quick and easy" payment and utilization controls, but certainly will not allow time for the development of efficient, community-based healthcare networks. The reduction in spending increases envisioned in the Clinton plan may not be too much, but it is certainly too fast for effective delivery reform.

2. Process for Setting the Global Budget

Our second recommendation for strengthening the Clinton proposal is to employ a more effective and realistic process for setting the global budget. Our reform proposal calls for a "top down/bottom up" national budget-setting process that would incorporate critical information on population needs and local system efficiencies over time. Our plan likewise outlines a series of "checks and balances" that would help ensure direct and explicit accountability to voters for each year's global budget.

In contrast, the President's plan calls for a "top down only" approach to a national budget as defined by a formula-driven rate of increase. In CHA's view, this approach misses an important opportunity to make healthcare expenditures not only more predictable and reasonable, but also more consistent with changing health needs, system capacity, and the public's own view with regard to the tradeoffs between healthcare and other important social goals.

3. Abortion

CHA strongly opposes on both moral and political grounds the inclusion of abortion in the guaranteed national benefit package of benefits provided under healthcare reform. While abortion is currently legal it is strongly opposed by millions of employers and taxpayers. This government should not compel them to pay for abortions. We believe that this position is shared by many members of the House and Senate. We are therefore hopeful that when Congress decides this issue it will come down in favor of keeping healthcare reform and legal abortion separate and distinct issues.

4. Conscience Clause

CHA firmly supports the inclusion of a strong conscience clause provision for individuals, institutions and employers in healthcare reform legislation. The President has stated his intention to include conscience clauses in his legislation. CHA will be working with the White House and Congress to ensure that the protection is adequate.

5. Maintaining the Professional Ethos in American Medicine

Most politically viable healthcare reform plans (including the President's proposal) would rely heavily on market forces to control healthcare costs and improve the quality of care. They would accomplish this by shifting most of the financial risk in healthcare from the purchasers of care (government and employers) to those who are providing the care, hospitals and doctors. The latter would be organized into accountable health plans that would compete with one another on price and quality for market share. Inefficient plans and/or low quality plans would either improve or fail and leave the market. In certain areas of the United States economic forces already are forcing local healthcare systems to reorganize themselves along these lines.

While it is hoped that these developments will result in lower cost/higher quality healthcare, it is important to recognize that they represent a profound shift from existing practice. During the past fifty years, healthcare providers have been largely shielded from financial risk and enabled thereby to treat their patients without regard to the economic consequences for the patient, themselves or society. This separation of financial accountability from clinical autonomy has helped to preserve a strong professional "patient-first" ethic in American medicine. While some patients are occasionally overtreated, few insured patients are ever systematically undertreated. Furthermore, most U.S. communities are able to develop and sustain reasonably good-to-high quality healthcare services. Nevertheless, most analysts believe that shielding the clinician and patient from the economic consequences of their actions has led to a level of inefficiency and high costs that is no longer economically or politically sustainable.

However, the implications of shifting financial risk to providers in the context of all-out price competition have not been carefully examined. It is quite possible that intense competition in some healthcare markets will unleash commercial influences that will overwhelm the professional ethos in American medicine, threatening patient care and undermining the long term stability of a community's healthcare resources.

At least two questions need to be addressed in this regard:

- How will patients fare when the treatment they need could make their provider less competitive in a market, less profitable or even force the provider into bankruptcy?
- Will AHPs owned by commercial interests beholden to distant shareholders abandon communities when their profits are squeezed (as they will be) and a higher return on investment can be achieved elsewhere in the economy?

These are critically important questions that have not received enough attention. We know from the savings and loan debacle that when economic incentives change and systems of accountability are relaxed individuals and society can be unintentionally saddled with very high costs.

E. THE MEASURE OF SUCCESS

Finally, Mr. Chairman, we conclude our testimony by returning to the point at which President Clinton opened this historic healthcare debate: a clear focus on values. Values are the beacons which guide us, especially in stormy times when our sense of direction can become distorted. But values also provide us with the standards by which we can measure our progress. How should we measure it in this debate? By one very simple standard: the availability of persons throughout America's future healthcare system who are motivated to help others.

However impressive governmental programs, universal coverage, fee schedules, "market opportunities," corporations and institutions may be, successful healthcare reform will come down to people caring for people. When we are sick and in need, it is the very small events in each of our lives that make the difference. At such times we ask, "Is someone there when I call? Do they make me feel like a human person? Can I maintain my dignity and self-respect?" These are the issues by which future generations of Americans, their families and communities will judge the success of what we are beginning today. They are the issues we must keep in front of us throughout this debate. It is what the American people expect of us and what we owe to them.

The CHAIRMAN. Thank you both for your very important, constructive statements and testimony. We have a great deal of respect from working with both of you, and I think all the members of the committee and the American people can understand why. It has been very positive and helpful testimony.

We will follow 7-minute rounds for questioning, and I will ask staff to keep us on track.

As I understand both Mr. Davidson and Sister Coyle, you will work with us, this committee and the other committees and the administration, in helping to achieve a program to reach the goals that you have outlined.

Mr. DAVIDSON. Absolutely, Mr. Chairman.

Sister COYLE. That is certainly true, and we at CHA have spent 2 years with a committee representing the broad section of consum-

ers and providers in determining the direction. We want to be very present to you, both in the technical and the philosophical and value-oriented sense.

The CHAIRMAN. That is enormously helpful. I think all of us look forward to continuing that relationship.

Mr. Davidson—and I would ask Sister Coyle as well if she might give a reaction—the areas in which we have agreement, as I understand it, are universal coverage——

Mr. DAVIDSON. [Nodding head.]

The CHAIRMAN. Let the record show that they both nodded their heads in approval.

Mr. DAVIDSON. Well, we can respond with more than a head nod.

Sister COYLE. Yes.

The CHAIRMAN. OK. Let me mention just three or four. You agree with universal coverage; you agree with employer contributions and individual contributions; you agree with protection for the poor; you agree with the national benefit package, and you agree with an independent commission or board. Am I correct?

Mr. DAVIDSON. Yes.

Sister COYLE. That is correct.

The CHAIRMAN. And you agree on antitrust changes. There are still areas within all of these, obviously, that have to be worked out, but you do agree that there have to be antitrust changes. You agree that there have to be integrated systems of care; you agree that there must be insurance reform, administrative simplification, and slowing of spending growth. Am I correct?

Sister COYLE. That is accurate, yes.

Mr. DAVIDSON. That latter question, I would like to hear again, Mr. Chairman.

The CHAIRMAN. Slowing spending growth.

Mr. DAVIDSON. We are certainly for slowing spending growth; it is the question of the strategy to get there.

The CHAIRMAN. As I understand, you would say "reasonable" but not "arbitrary."

Mr. DAVIDSON. We think behavior change is going to have some effect on spending growth. You asked us earlier the question about a willingness to work with the committee, and I think it is essential that you all understand that we have very strong feelings that the status quo is not sustainable, it doesn't not serve America well, and we need to move to a better place. We are committed to that, and we are committed to substantial change. We may disagree over some of the vehicles to get there, but when you listen to what it is that we have said we are for, we are calling for more dramatic behavior change among hospitals and doctors than perhaps anybody here in Washington.

So we are willing to work with you to deliver better services to communities, which should have the net effect of gaining some control over cost growth as opposed to an arbitrary way of setting caps and working backward.

So there is a very strong commitment, and I know that is how Sister feels; we have talked about this. The hospital community feels very strongly that they want to see change.

Sister COYLE. To add to that, we believe that merely addressing the financing will not solve the problem, that we need a substan-

tial, fundamental reshaping of our health care system, and that ways in which we work together as partners in the concept of an integrated delivery network will in fact be an efficient, cost-effective, and still quality-driven system.

The CHAIRMAN. As time is moving along, let me ask your reaction to the benefit package under the President's plan. Is it too broad? Is it a Cadillac, or a Ford, or what could you say about that? Do you think it is in the ball park?

Sister COYLE. From the description Mrs. Clinton has given, I believe that the benefit package as they have constructed it is comparable to the package of a Fortune 500 company. If that is true, then certainly, that would meet our expectations. We believe that a benefit package should be broad enough to include those benefits that middle class citizens in our society have at the present time.

The CHAIRMAN. Mr. Davidson.

Mr. DAVIDSON. Mr. Chairman, we see a pretty comprehensive package there. We think that probably you are going to have to face the question of some limits on some of those benefits and that the national commission that should oversee this ought to be thinking through times when we can expand benefits. But we think it is a pretty basic and fundamental package that would serve a lot of Americans quite well.

The CHAIRMAN. Senator Kassebaum.

Senator KASSEBAUM. Thank you, Mr. Chairman.

I was very impressed with both statements. You both understand well the problems of the hospitals as being on the front lines. I totally agree with both of your comments about fully incorporating Medicare into the system of reform. I think the cost-shifting that would continue to occur would be a terrible problem if this integration does not occur.

Is that your basic concern?

Mr. DAVIDSON. Well, that is certainly one concern, in other words, that we are going to stay with the current payment system and keep squeezing it back, which ultimately, the current payment system is underpaying hospitals and their care for the elderly now, which means that we will have further reductions in it. Two out of three hospitals that treat Medicare patients lose money in the process of treating them. The Medicare program is paying on average at about 88 to 90 cents on the dollar, so if we squeeze tighter and still deliver care in the same way, we are going to have a serious set of problems—we have missed the point, and the point is to change the delivery system and the way we treat senior citizens. We could do better.

Senator KASSEBAUM. Sister Coyle.

Sister COYLE. Not addressing the Medicare issue and including it is again a fragmented approach to health care reform. We believe in a reformed system that provides a continuum of care. That means all forms of care. We believe that other sources of revenue ought to be looked at rather than Medicare reductions.

As you both know, too, it is particularly hard on rural hospitals, where such a large percent of the patient population is Medicare.

I was interested in both of your talking about reform of the delivery system and the importance of an integrated system of care. One question that I would have is in talking about moving to an

integrated delivery system, how would you envision incorporating perhaps the support for some for a medical savings account? Obviously, I think all of us would like to see a medical savings account somehow be a part of the system, but how would you envision it as part of an integrated system of care and an ability to stress individual responsibility?

Mr. DAVIDSON. I think in any reform notions that we move toward, we are going to see individual participation in paying for the care; the whole idea of medical IRAs as a way to supplement that individual payment would make some sense in any redesigned system.

Sister COYLE. Again, I think we are talking about shared responsibility, and the part that every individual ought to be playing in a reformed system.

Senator KASSEBAUM. And finally, just to touch on the health alliances. I have worried that this structure could become too monopolistic in its current form. Both of you spoke about the importance of community and regions, obviously, having differences that need to be addressed. Do you think that the health alliance structure allows enough flexibility? Do you worry that it could become too intrusive and be difficult to shape, State by State? I mean, one State may have a very different approach through their health alliance structure than the adjoining State. What problems do each of you see with a health alliance structure?

Mr. DAVIDSON. I think the worry that many of us have is that the health alliance strategy is kind of the linchpin of the plan; that we have a lot that we are banking on in it being successful. We are talking about creating 50 or more organizations that do not exist today. When you just begin to think about the mechanics of that, that means developing a governance structure, that means developing a staff, a management information system, and so forth.

Our view is that we think it is important to create that kind of an approach at the State level, but perhaps we ought to move it along slowly and start it off with its original notion. The original notion of the purchasing alliance was to in essence create something like a farmers' coop for the little guys, for the small employers who did not have any leverage in the market place, and you would provide them an opportunity with market reform and community rating to come together in the aggregate and better represent their interests. We think that is probably a good strategy.

Now, what is the cut-off point in terms of companies with a given number of employees? We do not know whether that is 50 or 100. But we think the idea of perhaps going slowly there would make more sense. To bank the whole operation on bringing everybody into the organizations that do not exist today is a bit risky, and we would urge rethinking some of that, and we think there is a way to work out some common ground there.

Senator KASSEBAUM. Sister Coyle.

Sister COYLE. The concept of a health alliance, which we also have in the CHA plan, is very acceptable. We feel that there should be a brokerage type of arrangement so that objectivity and inclusivity are part of the reform system.

However, our emphasis is certainly on the local community, on the formation of integrated delivery networks where providers, par-

ticipants, and consumers together can assess community needs, can monitor the quality of health care service; that there would be an accountability built into the system at the local level as well as at the State level.

Senator KASSEBAUM. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Metzenbaum.

Senator METZENBAUM. Mr. Davidson and Sister, I might say how pleased I am to have somebody here from Ohio speaking for the Catholic hospitals of this country, and I know what a fine job you do at your own hospital in Cincinnati.

One of the areas that has concerned me vis-a-vis the question of cost has to do with the fact that just about every hospital in this country leases out on an exclusive basis departments to radiologists, anesthesiologists and pathologists. There is really no medical reason for that that I can understand, but the pressure of the organization has now made it possible for these three specialties to become some of the highest paid medical practitioners in the country.

Wouldn't you agree that hospitals could achieve some economies by making it possible to have competitive procedures available in the hospital or, absent that, and probably the best way, if you follow the procedure that used to be the case, the pathologist used to be on the payroll of the hospitals. Then they decided they were independent, and they had the right to act as professionals, and that they would run these departments. But the patient winds up getting a bill for anything they want to change. The hospitals don't provide any pressure to keep the prices down, and it has become a runaway situation for these various professions.

I am much disturbed about this. I think we ought to be doing something about it, and I would like to get your views.

Mr. DAVIDSON. Senator, there is great variation in practices among hospitals across the country in terms of their contracting relationships with anesthesiologists and radiologists and so forth. It is hard to generalize the way those matters are treated. In some cases, there is a lot of internal oversight, monitoring of charges to patients, and all the rest; in others, they are exclusive franchises where the group makes a determination.

If we were going to continue the hospital system as we know it today, then this issue is one that would need to be looked at very carefully. But we are talking about developing a system that is very different, integrating hospitals together with physicians and being paid on a capitated basis, which will provide us new incentives to provide services at the lowest cost possible, which should deal with individual pricing arrangements within our institutions. We think that there will be the leverage there to deal with these issues in this new capitated arrangement.

Senator METZENBAUM. Mr. Davidson, you and I and my staff worked out a procedure dealing with the antitrust problems hospitals had, and we came out very well. I think that was your problem, and we tried to work with you, and we did work with you, and we helped solve it. This one is my problem, and I think the American people's problem. I would like to see if we couldn't work out something on this subject to prevent these runaway costs becoming affixed to the cost of medical care, or continuing to be affixed to the

cost of medical care in this country, and I would to explore the subject with you.

Mr. DAVIDSON. We would be very happy to speak with you, Senator.

Senator METZENBAUM. Sister, do you have any comment on this?

Sister COYLE. Yes, Senator. I think that we are talking about a reformed system. But I am aware of initiatives that are already taking place that are perhaps returning us to our original purpose in providing health care, being a service and not a commodity.

Just this past month in Cincinnati, OH, six hospitals with an insurance group with 1,000 physicians and 100 pharmacies created an integrated network. It is called "New Health." That shows ways by which insurance groups, physicians, providers, and pharmacies can work together, giving people a broad range of choice. One thousand physicians are in this particular network.

I point this out because I think it is beginning to say to the health care industry and to our local communities that partnerships, networks, in providing health care are going to be for the best service of our people, and that is why we are in the business.

Senator METZENBAUM. Sister, let me ask you what do you need the insurance companies for? What do they add? All the others contribute something. Insurance companies now get 25 cents out of every dollar that is spent for medical services, and it seems to me that you can form health care associations without the insurance companies. I don't have any antipathy toward the insurance companies, but the fact is if you do not need them, then why are you paying for it?

Sister COYLE. Well, I think in this situation, the insurance company was already part of the structure, and they already are holding contracts with a number of purchasers. I believe this is an incremental step. But the need to reform the insurance industry is also part of health care reform, and I do not think in Cincinnati, OH, we are able to abolish the insurance industry tomorrow.

Senator METZENBAUM. I am not suggesting that we abolish the insurance industry. They provide a very useful factor in our economy. But in the health care field, I do not think that they are a necessity, and therefore I think one of the big battles that we in Congress are going to have is the effort of the insurance industry to preserve its position and its ability to reap in hundreds of millions of dollars for doing the administrative work. If we could eliminate that, it would seem to me that there would be tremendous economy. There are many other areas for the insurance industry to operate in other than this one, as I see it.

Sister COYLE. I think that will be an issue that will be part of the debate and discussion. But we as the CHA have called for bringing insurance providers into the concept of managed care.

Senator METZENBAUM. Mr. Davidson, this is my last question. The American Hospital Association has proposed the creation of community care networks to provide health care to individuals. Do you believe these networks will be able to compete against the big insurance companies?

Mr. DAVIDSON. I guess if you were to look at a forecast of what is going to happen over the next decade, we will probably see a restructuring of the health insurance field. When you move to a sys-

tem of community rating and change the nature of their business, we will see a reduction in the number of insurers. I think you will see partnerships developing, integration of not only delivery systems of hospitals and doctors, but partnerships with insurance companies.

So I think you are going to see a lot of change in that field, driven by a different set of values and a different set of incentives. So I think you are going to be seeing lots and lots of change.

Senator METZENBAUM. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Jeffords.

Senator JEFFORDS. Thank you, Mr. Chairman.

I appreciate your testimony, and I am very interested in some specific aspects of it. With respect to Medicare, you suggest that it would be wise to have sort of a seamless system and not have two systems. Can you think of any disadvantage to the elderly of having it as one system?

Mr. DAVIDSON. I think for the elderly—and I must share a personal experience. In our family, we have lost three parents in the past year and a half, and on the basis of that experience and how care was accommodated and coordinated and the degree of collaboration that exists, I guess I learned from that experience that we could do a lot better.

I think the concern that elderly patients have when we begin to talk about these changes is the fear of the unknown, of if you change something, will it be better for me, and since I don't know about it, I am nervous about it. I think that what we have got to do is to assure people that we can deliver care perhaps better than we do today. We can do a better job of taking care of patients. For an awful lot of people in America, the elderly as well as middle aged, many of us are in charge of our own care, and we make decisions about what kinds of physicians we see. No one coordinates it. So we think there is a way to treat all patients better, and for the elderly, if we are going to move them into a new kind of system, we are going to have to persuade them of that, and give them a demonstration that care for them could be better.

Senator JEFFORDS. Sister Coyle.

Sister COYLE. I agree with Dick. I think that maintaining the current status with Medicare perpetuates the treatment and cure approach. We are looking at a holistic, preventive promotion of health approach, and to me, that would be very much more incorporated by having Medicare part of the total package.

Senator JEFFORDS. Thank you.

One of the presumptions that is made by the Clinton plan is that there are so many inefficiencies and problems in our system that if we become more efficient and can operate better that we can operate without huge additional resources. In making that conclusion, they note that we spend twice as much as most industrialized nations do per capita for our health care right now. I just came back from Taiwan, where they are in the process of health care reform, and they spend 4 percent of their GDP, and they have better statistics than we do.

Second, there is no evidence from commonly used statistics that we are really reaching any better results, holistically, anyway, in health care by our present system.

And third, there are such inefficiencies—such as those noted by Dr. Elwood, which are startling, that maybe as much as one-third of our health care is either nonproductive or counterproductive—and with the medical malpractice, defensive medicine paperwork and the cost-shifting that goes on, that perhaps we can live within our present budget and even do things better.

Do you agree or disagree with that?

Mr. DAVIDSON. I think we would certainly agree that we can do better. The degree of savings from administrative cost changes may get exaggerated, but there are plenty of savings involved. There are certainly savings involved in coordinating care more effectively. Just within a given hospital, if you begin to study procedure, from the time we order a test to the time the results get into a physician's hands and then a treatment protocol begins, there are lots of ways that we could be more efficient.

We see the efficiencies growing out of, again, the delivery system change. Let me give you a for instance. On any given day in an American hospital, people who work there on nursing stations are confronted with 150 different utilization review forms from insurance companies. And the insurance companies are not willing to share the nature of these things, and you can't get them coordinated. And they add little or not value to the quality of patient care, yet we spend a lot of time filling forms out, responding to phone calls as to whether this procedure is appropriate, necessary, or can we move ahead with this protocol.

That alone, just in coordinating the whole utilization and review process in a better way, would make good sense. When we talk about delivery system reform, we see internal focus on real value-driven indicators of quality, looking at medical outcomes and getting rid of a lot of the paper that does not add any value to patient care.

So there are savings there, but you cannot pick these savings up and put them in a bucket and say we are going to make that bucket of money available for new benefits; in other words, these are things that will come out of the system over time. But it is going to take a lot of time, Senator.

Senator JEFFORDS. Well, what does that mean at the bottom line? Does that mean you do not believe we can live substantially within our present resources dedicated to health care, that we will have to raise substantial amounts of revenue, or that we can live within the present budget and make the efficiencies to provide us additional revenue to take care of additional benefits?

Mr. DAVIDSON. If we were to bring 37 million more Americans into mainstream health care in the next 4 years, we obviously would be incurring more costs. Yet there are savings to be gained down the line by getting everybody into organized delivery systems.

So I think you are going to see two lines that pass each other at some point, and it is hard to forecast where that point is.

Senator JEFFORDS. But 37 million Americans are getting health care; they are not being left to die in the alleys, are they? Isn't that cost-shifted to somebody else?

Mr. DAVIDSON. Well, they are the people who show up at our doors for care. There are millions of Americans who do not get care, who defer care. Ultimately, when they arrive at a hospital door, they are in much more serious condition than they are otherwise.

Senator JEFFORDS. But they get care at that point even though it is more costly; right?

Mr. DAVIDSON. Generally, when that is an emergency.

Sister COYLE. But the reason it is more costly is because they have not had preventive care. For example, with the neonatal and prenatal situations, we have women who do not have appropriate care during the term of pregnancy, and at the point when they are ready to delivery, very often the cost of delivery and the care of newborn babies that need intensive care within our facilities has escalated because there has not been a pattern of healthy habits.

So when we talk about a reformed system, we are talking about everyone having access to care.

Senator JEFFORDS. And that preventive health care would have been cheaper than the acute health care, would it not?

Sister COYLE. Overall, it will be. And that is one of the failings of our society——

Senator JEFFORDS. I am running out of time, and I do want to get one provincial question in. Vermont has some of the lowest costs in the country. Are you concerned about what will happen if we have a universal capping of costs and so on for those States and hospitals which have proved to be more efficient; or, how do you see the system as presently devised being able to handle the differences in the per capita costs of various hospitals, and what kinds of problems do you foresee?

Senator WELLSTONE. [Presiding.] Would the Senator yield for a moment, and if you could be kind enough to be relatively brief—I am trying to chair, but also vote, so I'd like to have the chance to get in a couple questions before I have to leave.

Senator JEFFORDS. Oh, is there a vote on?

Senator WELLSTONE. Yes, in just 1 minute.

Senator JEFFORDS. OK. This is my last question. It is not exactly one that is easy to answer in a few words, however.

Mr. DAVIDSON. I think your concern is very legitimate. Look at States that have somehow experienced lower health care costs than others. If you ultimately move some kind of an arbitrary cap onto these things, you lock people in at a lower cost level, have less ability for growth—I think that is one of the reasons we are against any kind of an arbitrary cap. We have to build the system from the bottom up to make a determination of appropriate spending levels, and there are going to be variations geographically, and Vermont ought to be rewarded for being low cost, and Kansas ought to be rewarded for being low cost. We have got to find a way to do that, and a straight, arbitrary formula will not get you there, and that is one of the areas we are concerned about.

Sister COYLE. And I think that is our primary concern about the present concept regarding the global budget. The formula approach needs to be addressed in light of local population needs, statewide resources, and health care patterns. I think that is what is missing in the Clinton proposal.

Senator JEFFORDS. Thank you.

Senator WELLSTONE. Thank you.

I wonder if I could be very direct and just lay my major concern right out on the table. Again, in today's Washington Post, there is a charge of recent health care mergers. In June, Galen Healthcare takes over. There is a merger of Galen and Columbia. In July, Merck and Medco; in August, Humana takes over Group Health. And now, we have Columbia and HCA, the Hospital Corporation of America, merging.

A New York Times headline: "Health Industry is moving to form service networks."

My concern about this is that I think we may not be moving toward competition, but rather toward collusion. We may be moving toward oligopoly at best. And the big question for people in our country is going to be who manages the managed competition.

And the second question, one more time—and I am a huge proponent of health care perform, and I come at it from a single-payer perspective—but one thing I don't want to see happen is bottom line medicine where the bottom line is the only line, and one thing I do not want to see happen is these conglomerates taking over with, I think, very severe damage done to the traditional doctor-patient relationship.

I will tell you one more time, Senator Durenberger is quite right about what happened in Minnesota, including that the largest medical society, in Ramsey County, is asking for a study of single-payer in our State, because of the experiences that caregivers had with some of the managed care plans. They have been micromanaged to death, to the extent that I think there is a considerable amount of demoralization.

I think when caregivers raise questions about this, they are raising these questions in very good faith. So I would like to ask you for a response to my proposal. I think built into whatever health care reform there is, there has to be an assurance that caregivers can have access to capital to set up their own independent networks. I do not want doctors and nurses and nurse practitioners and others to have to hang out an Aetna sign or a Travellers sign. Forty percent of these HMOs are already owned by an insurance company, and we are right now experiencing a buying frenzy; that is what these stories are about today. While we are talking here today, there is merger mania in health care.

What direction is this taking us in, and would you agree or not agree with this proposal that built into any reform effort should be that providers have to have access to capital.

Mr. DAVIDSON. Senator, in our testimony we made reference to the point that the whole question of alliances and their structure needed much more attention to assure that the accountable health plans that they work with represent local communities. That is how we have got to come at that.

You see on the business pages the mergers of investor-owned organizations; all across America, you have lots of hospital and doctor organizations talking to each other in local communities, seeing how we can reconfigure the capacity of the health delivery system to meet the demands of tomorrow. Those things do not make the business pages because they are generally being done by small, community-based institutions. But the underlying concern that we

do have, all of us, is how do we maintain community-based control of our organizations. How can we come together and make decisions at the community level about the appropriate levels of capacity? The Government cannot do it; it has not done that effectively in any State, and we think it ought to be done by community-based organizations that address your concerns.

Senator WELLSTONE. I would like to get to the community-based organizations, but do you or do you not think it is a proposal that is worth considering taking up that again the caregivers—I am just going to focus on that for a moment—have to have the capital and the wherewithal to be able to set up their own networks, if this is the direction we are going in, as opposed to having to hang out an Aetna sign? Because I see this whole thing going toward merger/conglomerate.

Sister COYLE. Senator Wellstone, we do not envision our health care system to be managed by Wall Street. It is essential that caregivers and consumers be active participants in assessing community needs and designing the types of integrated delivery or continuing care networks that will be community-focused.

Health care reform is about responding to the needs of people. It is not about building an additional corporation. We are very concerned that managed competition that focuses primarily on price and cost rather than on quality, scope of service and efficiency, will not be an appropriate, healthy approach to health care reform in our society.

Senator WELLSTONE. Well, Sister, that is precisely my concern.

Let me ask one more question of a different kind. I really appreciate—I followed your statement very carefully that we must at all costs avoid—and I quote—"creating a basic package that becomes a floor for the middle class and a ceiling for the poor." I just want to tell you, Sister, that I am going to continue—I tried once last week with an amendment, and I am going to have a different formulation—but the principle is going to be that whatever plan Senators and Representatives participate in by way of package of benefits and quality of services for ourselves and our families must be available and affordable for the people we represent. I think that has to be built into this. Otherwise, we have lots of tiers of benefits.

I am not asking you to respond and agree or disagree. I just want to let you know that I am going to continue to push that forward.

My question is this, on the community part, for both of you—the poor and where they figure in. If you have these alliances, maybe one, maybe several in a State, and then you have these networks that are competing, many of which are in fact going to be owned by insurance companies or get bought up—I am telling you, I know you don't want to see this happen, but I am telling you we are going to head toward monopoly, and we are going to head toward collusion and not competition. I mean, I read the articles about what the big insurance companies are planning on doing. They are competing to keep costs down. Why would they want to take care of poor people? What is the guarantee that we have any kind of infrastructure of delivery, like community health care clinics, public health, out in the community where people really get the care and

where they have some say? Where is the guarantee in this plan that that is going to happen?

Sister COYLE. First of all, we advocate that there would be an objective outside group, the alliance, for example, that would charter these integrated delivery networks, and that within them, there would be a range of service as well as population so that all of the poor are not shifted to one network as opposed to another. That is going to require monitoring by the alliance; it is also going to require the responsibility to share the burden, because the concept of capitation is based on spreading the risk, and if we have all the poor in one network, we have not spread the risk; we have consolidated it.

So it is very essential that in the forming of the networks, in the approval of the networks, there be specific guidelines that require a broad spectrum of the population to be served.

Senator WELLSTONE. This is a tremendous focus you are putting on the alliances.

My time is up. Senator Gregg, have you voted already?

Senator GREGG. Yes.

Senator WELLSTONE. Then why don't I let you go ahead, and then I will excuse myself.

Thank you very much. I would certainly like to pursue some of this with you.

I also, Senator Gregg, would like to include in the record a statement by Dr. Cecile Rose, who is the president of Physicians for a National Health Program, the PNHP, expressing some of their concerns about where fee-for-service fits in.

Thank you.

[The prepared statement of Dr. Rose follows:]

PREPARED STATEMENT OF CECILE ROSE

Good morning. My name is Dr. Cecile Rose, and I am the President of Physicians for a National Health Program (PNHP), a membership organization of 5,500 physicians in the United States. PNHP is organized to educate physicians and the general public on the merits of a Canadian-style, single-payer health care system, which we believe would meet the goals for reform outlined by President Clinton.

PNHP believes that the evidence supporting single-payer reform makes it a far better policy choice than the managed-competition approach favored by President Clinton. We believe that managed competition cannot achieve the administrative savings needed to expand coverage to the uninsured and underinsured. Single-payer reform, on the other hand, has been shown to achieve tremendous savings. The Congressional Budget Office released a report in July of this year comparing the four leading health care reform proposals. Single-payer evidenced by far the greatest amount of savings.

A study by the General Accounting Office in June 1991 found that the administrative savings using a Canadian system in the United States would be $67 billion per year. In 1993 that figure would be $90 billion annually. The cost of serving the newly insured and increasing coverage for the currently insured could be easily paid by these savings.

We fear that the administrative savings claimed for managed competition cannot be achieved. On the contrary, the market forces on which managed competition relies to restrain costs have not succeeded in doing so during 20 years of various state and private sector cost control initiatives.

We fear that managed competition will push all but the wealthy into stripped down versions of HMOs and assure a multi-tiered health care system, separate and unequal.

We fear that managed competition will deny most patients the right to choose or change their doctor and hospital, completing the transformation of American medicine from one-on-one doctor-patient relationships to a medical system run by insurance giants like Prudential and Aetna.

In half of America, the population is too sparse to allow competition; a town's only hospital can't compete with itself. In the rest of the nation, the big insurance companies, which will run the system, are more likely to collude to raise prices than to compete to lower them.

The Canadian approach is simple and straightforward: include everyone in a single public insurance program like Social Security; cover all needed care without co-payments or deductibles; and leave patients free to choose any doctor, clinic or hospital in the country. Since Canadians started their program 25 years ago, their life expectancy has soared—nearly two years higher than that of Americans. They pay 40 percent less for care than we do, and get more care: more doctor visits, more hospital care and even more bone-marrow transplants.

We support the principles President Clinton has outlined for his plan. Each principle can be achieved by single-payer reform.

Security—A single-payer system is based on universal coverage. Managed competition, on the other hand, would create an elaborate system to determine eligibility and set premiums. Even before the Clinton plan's official release, White House spokespeople discussed delaying the phase-in of universal coverage to soften the cost impact. The example of Massachusetts is illustrative of what could happen across the country. Five years after passage of universal health insurance legislation, more, not fewer, people are uninsured, and as costs have soared, the phase-in of the employer mandate has failed to materialize.

Simplicity—Single-payer reform will make the government the sole insurer, eliminating the need for duplicative and costly bureaucracy in the nation's 1,500 health insurance companies. Managed competition, on the other hand, will create a new layer of bureaucracy in the form of Health Alliances. Furthermore, the bureaucratic tasks assigned to the Health Alliances are daunting. They will administer premium caps; negotiate with and monitor health plans for quality of care, risk selection and financial abuses; set fees and capitation payments; collect premiums from millions of employers and hundreds of millions of individuals; and verify eligibility for premium subsidies available to the 45.6 million people whose incomes are at or below 150% of poverty. A single-payer approach, on the other hand, would require no income eligibility, no premium caps, and no concern about risk selection, since everyone is covered. The single-payer approach would sharply cut the $50 billion spent annually on insurance overhead by eliminating marketing costs, efforts at selective enrollment, stockholder's profits, executives' exorbitant salaries, and lobbying expenses.

Savings—The Government Accounting Office stated in June 1991 that the single-payer approach would save $67 billion per year in administrative costs. The Clinton proposal, relying solely on computerization and standardization of billing for administrative savings, is unlikely to save more than $7-8 billion per year.

The Clinton proposal would create Health Alliances, necessitating a complex regulatory mechanism to control premiums and hence to control costs. The single-payer system eliminates the need for such complexity, and therefore requires a much smaller administrative network. The Canadian health care system administration, employs approximately the same number of persons as does Blue Cross/Blue Shield in the state of Massachusetts alone!

Furthermore, insurance overhead in Canada's public system takes only one cent of each premium dollar; our private insurance companies and HMOs keep an average of 14 cents of every premium dollar in overhead.

Choice—The Clinton proposal claims it will allow freedom of choice. However, by shepherding most people into HMOs, most people will have fewer choices. A nationwide study of 17,000 patients released in August 1993 found that patients are widely dissatisfied with health maintenance organizations.

A single payer system allows for true choice. Canadians can choose any hospital or doctor, and may change providers at any time. Under managed competition, one must choose from those providers allowed within a particular plan.

Quality—A single payer system could apply all the techniques for quality improvement that managed competition proposes and apply them over the entire population, not merely within health plans. Providers would compete solely on the basis of quality since all costs would be equal.

Responsibility—The Clinton proposal will shift a significant cost of the new system onto small businesses, self-employed people, and middle and lower-income people. Many of the "savings" will be achieved by restricting or denying care, rather than by expanding care. Single-payer, on the other hand, is financed by progressive income and payroll taxes, eliminating the need for co-payments and deductibles, and making the system more equitable.

I hope you will seriously consider the potential for savings, simplicity, streamlining, and universal coverage achievable with a single-payer system. We in Physicians

for a National Health Program stand ready to work with you in ensuring that health care reform in this country incorporate the best mechanisms to meet the goals we all share.

Senator GREGG. As I understand your view, it is that the $238 in savings which the administration plan has suggested in the way of Medicare and Medicaid is too much and too fast, or too fast, anyway, and probably too much. And if I heard you, Sister, I think you used the phrase there should be another source of revenue. What is it—a VAT and higher income tax? What is the other source of revenue if these savings are not recognized in Medicare and Medicaid?

Sister COYLE. Well, I thought you were going to define that other source of revenue.

Senator GREGG. No. We are here to hear your suggestions, so why don't you give us some specific suggestions on where we'll find the revenue to pay for this fairly significant benefit package which now would be an entitlement?

Sister COYLE. I know that the Clinton proposal has already suggested a tax on the tobacco industry.

Senator GREGG. That is correct. I think they expect to get $105 billion; I'm not sure.

Sister COYLE. It believes that it is possible that a similar tax could be placed on the alcohol industry. I am looking at those industries that in some way contribute to the health needs within our society.

Senator GREGG. So you think that rather than this savings in Medicare and Medicaid, you could make up most of this cost increase through taxes on sin?

Sister COYLE. Well, I did not call it "sin." [Laughter.] Other people have referred to it as that. But I am looking at those behaviors in our society that contribute to the escalating cost of health care. Frankly, I really have not looked at other revenues, but——

Senator GREGG. Well, it is a big number; my point is it is a big number.

Sister COYLE. Yes.

Senator GREGG. The administration is talking $230 billion. Actually, I think their total number is $287 billion in total Federal savings. And I understand that the hospitals do not want to bear the brunt of that, because clearly, if Medicare and Medicaid are contracted in their rate of growth, you folks are probably going to bear the majority of that contraction as you did in the DRG program and other programs.

But that still leaves the gap. If you are going to have the benefits package—and in fact, you have suggested an even broader benefits package than what the administration has suggested, then you have got to pay for it somehow. And I guess I am just looking for ideas.

Sister COYLE. I also think that in addition to other sources of revenue, we need to look at other changes in societal behavior patterns that contribute to the cost of health care in our society, and that is a long-term savings that is not going to happen tomorrow.

Senator GREGG. I think the whole package is aimed at that primary preventive care, which is something I strongly support. But those are hard to quantify, as is the effect of insuring everyone and

how that will affect utilization. I mean, you have to presume that that is going to dramatically increase utilization from a lot of sectors that may not be taking advantage of the system now—and I do not mean taking advantage in a pejorative sense, but I mean just using the system. So those are difficult ones to quantify.

But what is quantifiable, using the administration numbers, which I happen to think are low—their estimates on the new entitlements are clearly low; their estimate of $4.5 billion which is now being adjusted upward, but is not enough in my opinion to pick up the early retirement item of that new entitlement; it is very low. Their long-term care entitlement is low. Their drug entitlement estimates are low. But using their numbers, they have got this number of $287 billion, of which 230-some-odd billion is made up of Medicare and Medicaid. And you folks are taking the position that that is too much to take out of your industry at this time, that hospitals cannot bear that, and so I guess you have answered the question. You think it should come from a tax on various activities which incur negative effects on the health care system.

Sister COYLE. That is one possibility to look at, yes.

Senator GREGG. Mr. Davidson, do you have any thoughts on this?

Mr. DAVIDSON. Well, I would like to separate the numbers. I specifically addressed the $124 billion in Medicare growth reductions over time, and then the Medicaid numbers are another set of numbers. There will be some legitimate savings on the Medicaid side as you ultimately move Medicaid beneficiaries out of current State-run programs into integrated delivery systems, but we do not know what those savings will be. But we think they are legitimate savings.

Senator GREGG. Do you have an idea? Do you have a ball park figure—5 percent, 10 percent?

Mr. DAVIDSON. That could be as good a guess as any. I would be hesitant to name a number except to say that there will be some.

But our specific reference to the Medicare program was addressing here a savings by treating Medicare the same as usual, and you cannot expect that to happen in those particular numbers. Eighty percent of the cuts do come from reductions in hospital payment.

So the question goes back, Senator, to the commitment to reaching universal access, and can we agree that that is a commitment people want to make. And then you have to face the hard choices of how you finance it. I certainly would agree with Sister in the whole notion that we ought to look at financing mechanisms that are tied to vehicles that contribute to the poor health of the Nation. You can begin to brainstorm that whole idea as to what else you might legitimately do.

Obviously, the excise tax on tobacco and distilled spirits is a legitimate question in terms of social policy. I mean, someone has raised the question of a firearms tax. You can go down the list. But they are legitimate questions. Someone has raised the question of whether or not we ought to have a national lottery, since there is a feeding frenzy on the development of gambling, and it tends to pay on the problems of the poor, and if the poor are users of the lottery system, then perhaps that is a strategy to have them contribute to health care. That is another kind of thing people are thinking about.

The point is that if we are going to be committed, we do have to make honest and hard choices, and we are prepared to work with you on that and to recognize that the question is the objective and how achievable is it, and can we continue to sustain the status quo, and what is the economic impact of doing nothing.

Senator GREGG. I am just trying to get to some hard numbers. On the $124 billion, which is what you are willing to discuss, the Medicare number, do you have a number that you feel the Hospital Association has agreed that they could absorb?

Mr. DAVIDSON. No, I do not, but we would be happy to work with you on some kind of forecast and estimate about what you might expect in changes in the delivery system if in fact Medicare were brought into the changed delivery system.

Senator GREGG. You have not done those yet?

Mr. DAVIDSON. No.

Senator GREGG. I was also wondering about the issue of utilization. In my State, I think it is about 60 percent—most hospitals, I guess, statewide—so you have a large number of beds which are not being utilized. This system is inevitably going to lead the administration system, or just about any system which fundamentally changes the way we deliver health care and addresses efficiencies, is going to lead to a contraction in the number of beds that are available.

Mr. DAVIDSON. Absolutely.

Senator GREGG. How do you address that in the context of rural hospitals, which are underutilized, which are not efficient for that reason; and should there be something in this that deals with that fact, or do we just close them?

Mr. DAVIDSON. Well, the way the current system is working, we are starving some of those institutions, and they will close. Whether they should or not is another question.

I think when we talk about reform, we talk about bringing institutions together to work together in collaboration where we can make some decisions about who should continue to exist and who should not, and if in fact you have to close a rural acute care hospital, what kind of service ought to remain in the community. Up until now, we have not had a real strategy or public process to deal with those questions.

Senator GREGG. I guess my question is—I asked Mrs. Clinton this question at one of our meetings, and I respected her response. She said, "Well, basically, our plan is to structure a plan where the marketplace settles that issue." I do not happen to think that is going to happen, but you are saying there should be something beyond the marketplace settling the issue of rural hospitals that are underutilized but that represent a community service, whether those stay open or close.

My question is do you have any proposals for us that we should be putting into this process.

Mr. DAVIDSON. Senator, there may be frontier institutions that somehow fall out of any of these new concepts of delivery. For instance, in the State of Montana—when we think of something more rural—hospital people have said that they are anxious to begin to come together and try to link the rural hospitals of Montana into

some kind of an organized delivery system. We were impressed with their vision and their view that they could make that happen.

There are going to be certain places where in fact this might not be able to be worked out, and the question is if there would be a great void for the community by that institution closing, then maybe we need to have some kind of Federal assistance to assist those particular institutions. I do not know how many fit into that category, but there may be some. That would be outside of the alliance structure as we see it proposed.

Senator GREGG. That is the concern I have. If I could ask one more——

Sister COYLE. Senator, we have a rural hospital in Martin, KY. We are currently reshaping that hospital. In its current pattern, it is quite costly. This has been a phenomenon over the past 20 years, that each one of our stand-alone hospitals has continued to escalate the amount of service and the nature of service. By forming a partnership with a neighboring hospital, we are beginning to redefine the presence of that hospital. It will be continuing in that community, but its service will be preventive as well as treatment and cure. I think that is what we are going to be looking at, because we just cannot abolish the rural hospitals if we believe that providing health care is a community responsibility.

Senator GREGG. I guess that is my concern. I think we may end up with abolishing a lot of the rural hospitals from an economic standpoint, but I am not sure that from a quality of service standpoint, that is the best approach.

Let me ask one more question of you, Sister. If the benefits package includes in it as a directive of the national board that abortions must be done, how is the Catholic medical hospital system going to address that issue?

Sister COYLE. Well, the Catholic Hospital Association is not ready to speculate on that "if" at this time. I believe we made our position clear that we perceive legal abortion and health care as separate and distinct issues. Through our own efforts, we will continue in the debate to maintain that voice. At this time we cannot and do not wish to speculate on another outcome.

Senator GREGG. Thank you.

The CHAIRMAN. Senator Simon.

Senator SIMON. Thank you, Mr. Chairman, and thank you both for your testimony.

Mr. Davidson, I heard you say something, and I did not quite catch it, and I looked through your written statement and did not see it. You expressed concern about the per-patient visit or stay basis for payment. Did I miss something?

Mr. DAVIDSON. A continuation of the current Medicare payment system proliferates a system that we have that has not been as efficient as it could be. What we are saying is that the whole notion of restructuring the health care delivery system cannot have a segmented set of patients. In other words, in rural areas of your State, you have some hospitals that may treat 60 percent who are elderly, and we are talking about changing the delivery system, but Medicare is going to continue to pay on a per-unit basis, per admission, per visit, and so forth, and that will get in the way of changing that system.

We are saying that we ought to have encouragement for senior citizens to join organized delivery systems that are paid on a capitated basis. We think that is essential, because otherwise, we are going to run a two-track system, and it will get in the way of restructuring the way we deliver health care, and I think we are going to get very frustrated, and we are going to fail. That is a very serious concern that we have.

Senator SIMON. As I look at the total program—and I think basically, it is a very sound program—but the two areas of concern that I have, you have touched upon. One is cost control. And I believe, Sister, it was you who expressed the concern that it is attempting to move too rapidly. I guess some of us have the feeling it is not moving rapidly enough.

The second concern I have is that we are all guessing in terms of utilization, but when you add the 37 or 38 million people who are uncovered, it does seem to me that we are likely to have fairly significant increases in demand—and I see Dr. Todd in back of you there—in terms of use of physicians, and also in terms of utilization of hospitals. But part of that can be good. In other words, you may have a hospital move from a 70 percent occupancy rate to an 80 percent occupancy rate.

Assuming that we move away from the savings on Medicare and Medicaid that are anticipated here, do you have any suggestions as to how we should pay for the costs that we are talking about?

Mr. DAVIDSON. How to finance the new costs, in terms of new revenue sources?

Senator SIMON. Yes.

Mr. DAVIDSON. We have talked about the excise taxes, consideration of a variety of options. And that, again, takes you back to what is our commitment to move to universal access. We have to determine how strongly we feel about that, and then once we have made a determination that we have strong feelings about it, then we have to make the hard choices on the financing options, and I guess the view that Sister and I have expressed is that we ought to consider revenue sources that are somehow tied to contributing to health problems in America. That is what takes you to the tobacco tax, the distilled alcohol tax, and you start to go down the list of other things that may be related to that.

Senator SIMON. Sister, do you want to add anything there?

Sister COYLE. No. My response is similar. I do think that over the long-term, we will see cost-effectiveness. Our concern at the present time is when I said too fast and too soon, that we cannot just attempt to reform the system and lose the emphasis on quality care, quality service, and shortcuts in the short term may be liabilities in the long-term.

Senator SIMON. But short term, you are talking about limiting growth to 11.6 percent the first year. Now, that does not sound like a very extravagant aim.

Mr. DAVIDSON. I do not think you heard us expressing special concern over that. It is the long-term forecast by the year 2000 that takes you down to inflation plus population. The health care field has never operated at straight inflation for a whole variety of good reasons, and the CPI is not always the best measure to be comparing health care costs against. I think that is our concern, Senator,

that those forecasts may be overly ambitious, and from a hospital perspective, on the Medicare side, 80 percent of those savings are going to be reduced payments to hospitals—and that is without changing the way you deliver Medicare services. That is why we make the point that you cannot make that happen and accrue savings unless you really begin to hone in on new ways to deliver services to America's senior citizens.

Senator SIMON. By the year 2000, the aim is 4.1 percent. Even under the present system, a representative—and I do not think he would mind my mentioning this—of General Electric mentioned that in the State of Ohio, by using managed competition, they brought down their costs to about 5.6 percent, which is not that far from 4.1 percent, and with additional savings that you should experience, it does not seem to me that 4.1 percent is that unrealistic.

What is wrong with my thinking here?

Mr. DAVIDSON. Senator, I do not know that there is anything wrong with your thinking, except that what we are talking about is substantial change that could turn out to be a crapshoot, and we think the issues are too significant to let it happen that way, and we need to be very careful as we progress. And I think that is what you hear us expressing.

Sister COYLE. I think our concern is about the timing and the ability to accomplish that amount of savings over the short period of time. That is probably less than 5-year period if you look at where we are today.

Senator SIMON. All right. Thank you both very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, I appreciate the pressure of the time, and I really regret very much that we do not have more time with these witnesses.

I have a series of questions that I would like to submit for response in writing. I must begin, however, where I left off, which was vocabulary versus language. There is no managed competition in the State of Ohio, and everybody knows that. There is some managed care going on, and again, that is a misnomer; some people are managing the costs, taking discount rates out of hospitals and doctors and so forth, and then there are, in some parts of the country, genuine organizations that try to manage care, and I am sure in Ohio there are some of those. There are a couple of cities in Ohio, as I recall—Cleveland, Cincinnati—that are trying to get the markets even in a very dysfunctional environment. But until we have national rules in which people can make choices based on information and have the resources to make those choices and have a genuine choice of providers from whom to buy that and rules for health plans and health alliances as we are debating, there is not going to be any managed competition; there will not be any managed competition until we get every community being rewarded for doing good things.

As I recall the Part A statistics during the 1980's, when we gave some appropriate signals to the hospital industry, they changed. You talked about behavior earlier; it changed. If you look at the Medicare increases in the 1980's, they did not come from Part A, and they did not come from hospitals, because hospital behavior

changed drastically in this country. The expenditures increased because nobody did anything about the Part B side.

I understand both of you to say that if we had a plan on the table now where the elderly and the disabled in this country who are Medicare-eligible could buy an accountable health plan in a community in which they function appropriately, rather than buying a Part A, Part B, Medigap and so forth, that if in fact those plans would coordinated the access to services in that community for an appropriate annual price, that you would favor that kind of system; you think it is important for the elderly and the disabled in this country to move in the direction of being treated the same way that everyone else in this country is treated in terms of comprehensive benefits, somebody to do their work for them other than HCFA, and that that would be fair to the elderly and the disabled, as well as enable communities to do a better job of finding the efficiencies in the provider system.

Mr. DAVIDSON. Yes, Senator, that is a view that we hold, and the view is that we ought to use the expansion of benefits as an incentive to enroll elderly people in these new kinds of delivery systems. In other words, consider the expansion of benefits for pharmaceuticals and long-term care as something you get by enrolling in an integrated delivery system.

There are other ways that we could provide incentives. I think the point that we are making—I don't know that we said we were opposed to what we see on the table because this is not in there—what we are saying is that we have serious concern that we will not achieve the objectives if we keep Medicare the way it is today, and we are going to frustrate each other. You will be angry with us, we will not be happy with you, and the elderly will not be better served. We have got to address that as a real issue.

Sister COYLE. We believe that placing the elderly in the plan really does integrate the continuum of care. It also would spread the financial risk more appropriately across the total community. It seems that if we are reforming the system to exclude a very significant portion, especially in the consumption of health care goods and costs, that we are really not reforming the total system.

Senator DURENBERGER. Would either of you take on the issue of capital? I do not know that that has been raised here yet. Particularly for hospitals, there is an over-investment, but maybe we need new investment in new kinds of hospitals. We have all experienced that in rural areas, and you might experience that in transition communities. Access to capital is critical.

Traditionally, you will have some kind of reserve in your payment system to use for that kind of investment. In capitated systems, in fixed-rate systems, in systems with budgets that constantly ratchet down—I am just guessing—but I would think you would be very apprehensive that the individual hospital institutions in this country would have the room, without the help of some other entity—for example, an accountable health plan or some kind of an integrated service network—someone who in effect spreads the risk of capital investment, to get the kind of capital that our communities are going to need to shut down some hospitals, transition the function of others, whatever it may be out

there. Would one or the other of you speak to the issue of capital and how that relates to the payment system?

Mr. DAVIDSON. One issue, specifically. In talking about new integrated delivery systems, the major area of new capital investment is going to be in information systems. What we learn as we talk through all of this and try to coordinate the connections of electronic information and standardized medical records and all the rest is that you are not going to see the building of buildings. You will see the changing in the configuration of buildings. You will see more care at home and in alternative settings to hospitals. But you are going to see very sophisticated information systems develop that cost an awful lot of money.

I was just with a hospital CEO from the State of Virginia that runs what we would call a community care network. They are looking at a potential $25 million investment next year, just in information system development. So the concern for capital is that we are probably talking about new capital configurations. Some of this will come through capitated payment, some of it will come with new partnerships with other players and all the rest. But it is a real issue; we cannot get from here to there without an infusion of capital, perhaps for different kinds of things than we have used in the past.

Sister COYLE. Yes, I agree. In fact, when you mentioned earlier in your opening remarks that there is much confusion about the vocabulary and having different meanings, I think that is also true in regard to how we image capital. In a reformed system and in a new approach to health care delivery, the emphasis shifts from brick and mortar to provision of care, to information systems, to those types of equipment that will better meet the needs of people.

Senator DURENBERGER. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Wofford.

Senator WOFFORD. It was very constructive, important testimony, what I heard and all that I have read, and I want to thank you both. I will not hold up the other panel, or you are going to be blocked from hearing them, Mr. Chairman.

Thank you.

Mr. DAVIDSON. Thank you, Senator.

Senator WOFFORD. I have many questions for you, and I look forward to getting together with you.

The CHAIRMAN. We will submit some written questions as well.

Thank you very, very much. It was very constructive and helpful presentation.

Mr. DAVIDSON. Thank you, Mr. Chairman.

Sister COYLE. Thank you.

The CHAIRMAN. Our next panel is composed of representatives of many of the most important organizations speaking for front-line providers of health care services.

Dr. James Todd is executive vice president of the AMA and is known to everyone here. He is a forceful spokesman for his membership and someone that I and other members have worked with closely for many years on a variety of issues.

Linda Shinn is the executive director of the American Nurses Association. The ANA represents a group of providers, American

nurses, who have been unswerving in their commitment to their patients and who can expect to play an even more important role under the health reform than they do today.

Dr. Leonard Lawrence is associate dean of the University of Texas School of Medicine at San Antonio, TX. He is also president of the National Medical Association. For over 20 years, he has been a medical educator, administrator, and physician, devoting himself to the needs of the medically underserved communities. The NMA speaks for African American physicians, especially for the concerns of minority patients.

Dr. Robert Graham is the executive vice president of the American Academy of Family Physicians, a key group representing primary care. Prior to joining the Family Physicians, Dr. Graham was a career officer of the Public Health Service and among many other posts, served as the director of health resources and services administration.

We are delighted to have had the opportunity to work with him on a number of different health measures in the past, and he has always been very constructive and helpful to this committee.

We are glad to have all of you here, and we will start with Dr. Todd.

STATEMENTS OF DR. JAMES S. TODD, EXECUTIVE VICE PRESIDENT, AMERICAN MEDICAL ASSOCIATION, WASHINGTON, DC; LINDA SHINN, R.N., EXECUTIVE DIRECTOR, AMERICAN NURSES ASSOCIATION, WASHINGTON, DC; DR. LEONARD LAWRENCE, PRESIDENT, NATIONAL MEDICAL ASSOCIATION, AND ASSOCIATE DEAN, UNIVERSITY OF TEXAS SCHOOL OF MEDICINE, SAN ANTONIO, TX; AND DR. ROBERT GRAHAM, EXECUTIVE VICE PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS, WASHINGTON, DC

Dr. TODD. Thank you, Mr. Chairman, and good morning, members of the committee.

I am Jim Todd, executive vice president of the American Medical Association. Let me say right up front that we applaud President Clinton as well as the First Lady for taking the first necessary step in bringing to an end the difficulties of far too many of our patients in finding affordable, adequate health care coverage.

The basic principles of the President's plan mirror what the American Medical Association has been calling for in its own reform proposal, "Health Access America," for the last 4 years. Both plans seek to build on what already works well in health care, and both would make certain that the health care system works fairly for all Americans.

We also understand the need to produce a system that is disciplined and can provide a measure of quality upon which our patients can rely.

Our plans also agree on the need for universal coverage, a national package of health benefits emphasizing preventive care; a requirement that all employers share in the responsibility of providing coverage that most employees in America have long enjoyed, while at the same time providing mechanisms to deal with the potential for dislocation among small employers and their employees; insurance reforms that will require insurers to insure risk rather

than avoid it; a competitive environment where health care costs at all levels will have to be justified; and a pluralism as a means of guaranteeing health care quality and access.

We are very pleased that in the various discussions we have had with the administration as it has crafted this proposal, many of the suggestions we offered were accepted.

In many other respects, however, we still do not see the necessary level of physician participation on behalf of their patients in some of the crucial aspects of the President's plan that we have discussed.

We understand that modification is ongoing, and we are encouraged that the President has signalled a willingness to negotiate the specifics of the plan. Yet right now, physicians have simply too many questions about how the plan will be implemented; about why the plan's effort to cut waste and spending does not go far enough in limiting liability costs through caps on noneconomic damages and meaningful limits on attorneys' fees; about why physicians will not be given adequate exemptions from current antitrust restraints to allow them to protect their patients' interests in a health care market that will be dominated by large managed care entities under this plan; about why strict spending controls are called for when they have never been shown to work anywhere else; about a national health board designed basically to regulate the system when better, more participatory models for providing guidance to the health care system are available; about health alliances that could add another level of regulatory authority to the system when all that is needed is an impartial entity that helps organize the way insurers and small employers come together in the marketplace; about the intent to nationalize medical education by essentially telling students what careers they may pursue—something done nowhere else in any field in this Nation; and finally, about why a whole new bureaucracy of quality oversight will be better than that now existing in the private sector.

Before physicians can say whether they oppose or support the President's plan, they need more detailed answers to these questions. Other health system reform plans have been and will continue to be offered from both sides of the aisle; none are perfect, nor should we expect them to be at this juncture. But on balance, the President deserves our congratulations for his unprecedented leadership in making, at long last, meaningful, comprehensive health system reform a real possibility.

We also congratulate this committee and its chairman not only for its past leadership but for quickly beginning the task of examining and shaping the President's plan. There is still much work to do, and at the end of this long process, when all is said and done, our litmus test will consist of only two questions: Will patients have the freedom to obtain care from the provider and facility of their choice, and can physicians provide necessary, effective, efficient care without undue restrictions on their clinical judgment?

Our patients deserve positive answers to these questions, and the AMA promises to work with the administration, the Congress, and our patients to see that positive answers will be achieved.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Dr. Todd follows:]

PREPARED STATEMENT OF JAMES S. TODD

Mr. Chair and Members of the Committee:

My name is James S. Todd, MD, Executive Vice President of the American Medical Association (AMA). Accompanying me is David L. Heidorn, JD, of the AMA's Division of Federal Legislation.

On behalf of the AMA's 300,000 member physicians, I am pleased and honored to be able to share with you what I believe many individual physicians would say about the President's proposal for health system reform if they had this opportunity to be here and talk with you today.

The President's proposal is long awaited. Physicians know the limitations of the current system. They see the difficulties far too many of Americans have finding affordable, adequate health care coverage. For the past four years, the AMA has been telling whomever would listen about the need for comprehensive reform and a way to achieve meaningful change through our own proposal, Health Access America. Before that, we helped organize an effort of leaders among physicians, a wide range of health care providers, academia, and both federal and state government to define the difficulties and solutions needed to address problems in the health care system—called Health Agenda for the American People—well before the problems of the health care system captured the public's attention as they have in the last several years.

We have long understood that problems with America's health care system had to be addressed, that the status quo was no longer sufficient. We applaud President Clinton for his resolve in addressing these problems, in taking the first necessary step to end the status quo. Likewise, we applaud the First Lady for her leadership in the difficult process of framing the President's proposal. It is encouraging to physicians that the President has signalled a willingness to negotiate details of the plan as long as such negotiation does not undermine the basic principles of reform. We look forward to such negotiations as the package proceeds through the Congress.

For these reasons alone, I can confidently say that the Administration, the Congress, the medical profession and others can move forward into a new era of health system reform.

BUILDING FAIRNESS INTO WHAT WORKS

Our confidence that we can accomplish our joint goals is fueled by how much there is in President Clinton's proposal that reflects our own plan for health system reform. Most importantly, we share President Clinton's intended goal of building on what works well in the system now, not replacing it or tearing it down. We also recognize that a strong theme in the President's proposal is enforcing fairness on a system that, for all the world-leading wonders in medical care it makes readily available to most Americans, does not fairly ensure that all Americans have access to that same level of care.

Every American should have coverage so that the system is available to every American, and the rules of the system should work the same for everyone. President Clinton's proposal would make a great leap in ensuring that they will—by making sure that all employers share in the responsibility of offering health care coverage that most employees in America have long enjoyed; by defining at the national level a package of health care benefits including preventive care that will be available to all Americans; by requiring health insurers to insure risk, not avoid or limit it; by reconstructing federal tax incentives so that the self-employed are treated the same as large corporations, and ending federal tax dollar underwriting of health care benefits richer than the nationally defined benefit package; and by establishing reasonable cost-sharing requirements that will encourage individuals to assume a level of responsibility for the health care choices they make. We are also encouraged that the plan recognizes the need for liability reform to be part of health system reform.

These changes alone would bring about a resolution of many of the difficulties our patients now experience in the health care system. Even more is needed, though. Unfortunately, many of the directions taken in the President's proposal beyond these basic principles create in physicians serious reservations about the effect the proposal, if enacted as it stands today, would have on the ability of physicians to provide quality health care to their patients.

ONE MEASURE: THE PHYSICIAN-PATIENT RELATIONSHIP

There is only one measure by which physicians will judge this proposal—how will it affect the ability of a physician and his or her patient together to make whatever decisions are necessary about the patient's medical needs. When a physician sits in an examining room with a patient facing a difficult, often life-threatening moment of decision, the physician needs to know, without doubt, that a decision can be made solely in the best interests of that patient's health and well-being, nothing else. As the President's proposal stands now, far too much could come between the physician and patient at that moment of truth, making it difficult to make the best possible decisions on behalf of patients.

The combination of arbitrary global budgets, premium caps and the need to save dollars by plans could necessitate many of the same intrusive controls and second guessing of physician decisions that exist in many of today's tightly controlled insurance plans. Such interference is, has been, and continues to be inappropriate. It is inappropriate now when insurance companies arbitrarily second-guess physicians' clinical decisions in utilization review or force physicians to step out of the examining room to seek preauthorization for necessary care. It is inappropriate when the threat of liability action forces physicians to order tests that would not be necessary in a less hostile environment.

Under a new health care system, we must avoid interference that results from decisions about the availability and quality of health care made from a bureaucratic, centralized place, distant from the patient's bedside, and disconnected from the needs of a physician's individual patient. There are many positive aspects of the President's plan that could and should be carried out with little government involvement, however new levels of bureaucracy are envisioned at the federal, state, and corporate levels. Physicians wonder what role will be left for them in the new system.

FEDERAL INTERFERENCE

At the federal level, a national health board of seven individuals would have sole responsibility for establishing, administering, and disciplining the system proposed by the President. One of its key responsibilities would be to enforce global budgets on health care spending. If such budgets were truly targets, meant as a flexible guide established with the help of physicians to assist in identifying cost difficulties and specific solutions, reflecting changing demographics and specific health care needs across the population, the AMA could support them. Instead, the "targets" here are strict spending controls based solely on changes in the Consumer Price Index and enforced through the cost of insurance premiums, with potential assessments on providers.

Nowhere in the world, in any kind of system that delivers any service or good to anyone, have such spending controls ever worked. Their implementation does nothing to control the demand for services and often times increases that demand. Such controls result in arbitrary maldistribution of services that often falls far short of meeting consumers' needs. With health care in the United States, the result will be no different. Treatment plans on how to meet individual patient needs now made between a physician and a patient in the physician's examining room could be made instead in Washington, DC. Physicians cannot accept this limitation. We do not believe our patients will either when beneficial care is not promptly available. That is not the kind of reform the American people are expecting.

Physicians have the same kinds of concerns about the control the federal government will be taking over the supply of physicians under the President's proposal. By mandating medical schools to train 50% of their physicians in primary care and allocating medical residency slots through new national and regional graduate medical education councils, the federal government will essentially nationalize medical education in this country. While there is a need for more primary care physicians throughout the nation, the incentives to practice primary care included in the President's plan, along with changes in the health care marketplace that are already happening, may well be enough to encourage and enable medical students to pursue primary care. The AMA has advocated for these same incentives for a long time. They should finally be given an opportunity to work.

STATE INTERFERENCE

At the state level, health alliances, as proposed in the President's plan, will only add to this bureaucratization of the health care system, providing another layer of decision-making which could undermine the physician-patient relationship. The AMA has watched with interest the development of the concept of health alliances

in the managed competition proposals that have come before Congress. In a pure managed competition approach, health alliances—or insurance purchasing cooperatives—would act simply as unbiased conduits between health insurance plans and consumers, acting to organize the market under rules that apply equally to all. There is a need for such a role to be played to help small businesses organize their purchasing power in the insurance market. Such a system—the Federal Employee Health Benefit Plan (FEHBP)—provides health benefits to federal workers, members of Congress, and their dependents. With little bureaucracy, FEHBP empowers individuals to make rational insurance purchasing decisions based on their needs and desires. The American people deserve no less.

President Clinton's proposal for health alliances goes beyond this basic need, however, giving alliances what will amount to regulatory command and control authority, in concert with the national board, to enforce premium prices on insurance plans and exclude plans with higher premiums. Authority also is given to alliances to determine what kinds of health plans would be allowed to compete by limiting the number of fee-for-service plans under an alliance. This is not competition. We recognize the need to manage competition fairly, but this limitation is not fair and is not going to promote competition, which is the only way that cost-effectiveness and quality health care can be guaranteed. An open fee-for-service plan should be available in every area of the country.

The proposal for health alliances is also problematic in that it requires all employers with up to 5000 employees to purchase coverage through them. Such a high threshold will give alliances far too much market power in a state or region, choking off pluralism and competition in a market. It is truly small employers, those with less than 500 employees, that need government help in pooling their resources to buy insurance, not employers with thousands of employees. Government involvement should be limited to where there is a need, allowing competition to work where it is able. Allowing medium sized employers to maintain their own plans will provide an appropriate counterbalance to the power of the alliance and will provide freedom for an expanded number of plans in any particular geographic area.

CORPORATE INTERFERENCE

Finally, physicians see the erosion of their professional decision-making role and their ability to represent the best interests of their patients in the overwhelming preference the plan gives to what will no doubt become large corporate managed health care entities. The AMA does not oppose managed care. We understand the current economic pressures that are already pushing more and more physicians into managed care arrangements. That is competition, for now. A health care reform plan should not, however, codify that marketplace phenomenon. If fee-for-service is truly noncompetitive, our patients should make that decision, not the federal government. Government action should at least he neutral, or, where there is a dominance in a 8 market, should help balance the marketplace to encourage competition.

Instead, we see an overly narrow definition of fee-for-service under a proposal labeled fee- for-service that eliminates many of the elements of fee-for-service. Rather than giving physicians and patients the ability to choose how and where medical care is delivered, and how much the service should cost, the government will impose a price on services that all physicians choosing to practice outside large managed care entities will have to accept. It is doubtful whether many physicians will be able to make this choice outside of already underserved areas of the country where managed care corporations will not find it cost-effective to go. In a short time, managed care will have no competition in the marketplace. A physician will have little choice if she or he cannot agree to managed care decisions that limit her or his ability to meet patient's medical needs. Such a situation is unacceptable to physicians. The fee-for service option, as proposed by the President combined with the global budget would limit patient freedom of choice to only an IPA/HMO type of fee-for service plan.

True fee-for-service, without arbitrary constraints, should be given an opportunity to fully compete in a new health system. Instead of price controls, a reimbursement system based on the RBRVS could be created, giving patients an opportunity to compare prices based on physicians' choices of conversion factors they individually want to apply.

Also needed are greatly expanded protections from anti-trust constraints for physicians to ban together and organize networks to compete with the accumulation of health care market power in large corporate entities. Physician organizations like the AMA should be allowed to represent physicians. Current restraints on such activities are already no longer valid where individual physicians have little choice but to accept arrangements offered to them.

Physicians also must be given the opportunity to compete for patients in such markets, by requiring dominant managed care entities to allow physicians who meet credential requirements to provide care under a managed care arrangement. Large corporate entities should not be allowed to freeze otherwise qualified physicians out of providing needed care to their patients if those patients want to choose that physician.

FINANCING

Fueling physicians' concern over the President's proposal is the light brush that has been given to financing the plan. The key revenue source offered is a continued federal cutback in Medicare and Medicaid funding. Not only is this unacceptable to physicians and their patients who rely on these already underfunded programs, it is doubtful that this can be a reliable revenue source to fund the expansion of health care access hoped for in the proposal. An increased "sin" tax on tobacco has been proposed by the President, which the AMA would support. We would also support increased taxes on alcohol as well as increased cost savings that will come with administrative savings envisioned in the plan.

With some reservations, the administrative cost savings offered in the plan are laudable and necessary. But given the bureaucratization of health care at the federal, state, and corporate level provided in the plan, we see, in fact, greater administrative costs, not less. For example, the National Board will have numerous sub boards and commissions, such as in quality, benefits, graduate medical education, that will all need to develop complex rules and regulations. A system that adds levels of management, not reduces them, can only be more expensive. The absurd duplication of oversight over the physician-patient relationship physicians now experience under insurance company control will not lessen under a system dominated by large corporate health care entities; more oversight is only added through the new state and federal superstructure of control. We simply do not see sufficient administrative cost savings in the President's proposal.

And where there are unnecessary costs in the system in the high cost of liability both in litigation costs and defensive medicine, the President's proposal takes too little action. To ensure such high costs do not continue under a new system, initiatives similar to those taken by California under its MICRA liability reform law should be enacted. A $250,000 limit on noneconomic damages must be established if true cost savings are to be achieved, and limits on attorneys' fees significantly below the 33 1/3 percent limit proposed by the plan are needed. That is no limit at all, since this is the typical share of awards taken from their clients now.

Physicians need to know from where the actual financing of the President's proposal will come.

CONCLUSION

The President and the First Lady should receive full credit for advancing the health reform issues and ensuring that health system reform has finally begun. Now, Congress has an unprecedented opportunity to enact legislation that will change forever the way health care is delivered in this nation. It is our intent to help ensure that change is for the positive, so that all Americans can receive the high quality, personal medical care that most Americans now receive from their physicians. That is our goal.

My comments today are general. It is my intent to provide an overview of our more basic concerns as the President's proposal applies to physicians' ability to continue to serve in their professional role of providing medical care to their patients, without constraint, a matter on which physicians have serious reservations. (A detailed response to the President's plan is attached.) As the members of this Committee well know, many hearings can and will be held on these and many more specific issues over the next several months. I hope and trust that the AMA will have the opportunity to make more specific comments when the time is appropriate.

THE PRESIDENT'S PROGRAM	AMA'S RESPONSE
Coverage All US citizens & pal residents must enroll in health insurance plans. Plans may be purchased through a state regional health alliance. A large employer (more than 5000 employees) may provide coverage through its own alliance. Health security card entitles each to nationally defined comprehensive benefit package. Government employees, Medicaid beneficiaries, and retirees under age 65 also purchase through alliances. Medicare, military health care, VA, and Indian Health Service continue.	Purchasing cooperatives can be useful in helping small businesses pool their purchasing power to buy insurance. Large employers should remain outside of alliances to create true competition. As envisioned here, though, Alliances have far too much market influence and must serve a regulatory role under the control of the national health board. For alliances to work, large employers must be defined at more than 500 employees, not 5000. It is truly small employers, not ones with thousands of employees, who now have problems buying insurance and could use alliances. By including large employers, alliances will monopolize markets thereby reducing competition and concurrent control of health care decisions. Also, the Alliances are far too much under the control of the national health board to be effective, especially because of the budget caps they must enforce. Rather than helping improve the insurance market, alliances will serve as regulators, thereby bureaucratizing the health care system even more than it is now.
Employer Requirement All employers must pay 80% of weighted avg plan premium for all employees with pro rata contribution for part-time employees under 30 hrs a week. But employer contribution is capped at 7.9% of payroll. Small employers (less than 50 employees) are capped between 3.5% and 6.8%, depending on employee avg annual wages. Corporate alliances, self insured large employers ($5,000+) and equally large union plans may self fund, contract with health plan, or arrange coverage through alliance; but must generally meet same requirements as insured plans.	The AMA believes that the best way to achieve meaningful health reform is to build on the existing employer-based health insurance system. The inequities in the current system should be addressed without sacrificing the health care quality and access that most Americans enjoy. This goal can be achieved through an employer requirement with appropriate protections for small businesses. Likewise, it is critical for employers to contribute the same percentage of premium to whichever plan its employees choose, otherwise the system is biased toward managed care. The percent of payroll cap is too low for large business, discouraging them from establishing their own plans, therefore increasing monopsony buying power of the Alliances.
Employee/Individual Requirement Employees pay 20% of weighted avg cost alliance health plan, depending on its cost. Self-employed and unemployed pay 100%, but anyone below 150% of poverty receives federal premium assistance from alliance. Undocumented aliens not eligible, but federal aid to institutions for their care continues. States must address migrant worker issues.	The federal government must increase, not reduce its funding and leadership in addressing undocumented individuals and migrant workers. Problems associated with providing them care go far beyond states' resources. Assistance should be provided for individuals and families with incomes under 200% of the poverty rate.
Nationally Defined Benefit Package Comprehensive medical, clinical preventive services based on periodicity schedule, hospice and home health; 30 days episode and 60 days/yr inpatient mental health substance abuse with 30 visits/yr psychotherapy; family planning, pregnancy-related; hospice; outpatient prescription drugs, rehab, DME and prosthetic/orthotic devices, vision/hearing; preventive dental for children, health education.	The preventive benefit package is inadequate and doesn't appear to use most current data. Other benefits are not inconsistent with AMA's own recommendations for a standard benefit package. But much more detail is needed. Any national health board updating of this package should be subject to Congressional approval. Coverage for mental health/substance abuse should mirror medical care.
Cost Sharing Health plans may offer 1 of 3 options. • Low cost sharing -- no deductible, $10 copay for outpatient service but none for inpatient, 10% coinsurance point-of-service option, $1500 individual $3000 family out-of-pocket max, $5 copay for prescription. • High cost sharing -- none for preventive, $200/$400 deductible, 20% coinsurance and same out-of-pocket max for inpatient/outpatient, $250/yr deductible, 20% coinsurance, and same out-of-pocket max for drugs. • Combination -- low cost sharing if preferred providers used and higher cost sharing with 20% coinsurance for out-of-network providers, same out-of-pocket max.	Under low cost sharing, 40% coinsurance for a point-of-service option is unacceptable, especially under a plan that will allow managed care plans to dominate the market. To help ensure the quality of managed care, patients must be given a reasonable opportunity to see physicians outside a plan. Further, managed care plans should be required to accept any physician who meets stated credentials and who agrees to provide services under an agreement with the plan and subject to plan capacity. Health Medical Savings Accounts (MSA) should be authorized to assist individuals and families in meeting out of pocket expenses including co-insurance and deductibles. Plan should authorize individuals to contract for any health services they want with their own after-tax funds.
National Health Board National Board oversees the establishment and administration of the new system. President appoints 7 members to staggered 3-yr terms who then are federal employees and may not have health care assets; 1 must represent states. Duties include: • implementing and enforcing national health spending budget • establishing state plan requirements, monitoring compliance • reviewing alliance plans submitted by states, with enforcement through HHS and Treasury • interpreting/updating benefit package • setting quality management/improvement system • commenting on breakthrough drug prices, but cannot control drug prices.	The AMA unequivocally opposes a national health spending budget and giving a national board responsibility for implementing and enforcing one. Such centralized decision-making and artificial spending have never worked anywhere and will quickly bring about difficulties in health care access and quality. A truly representative national commission may be able to help in setting goals for the health care system for expanding access, and in setting budget goals that take into account disease and demographic changes and changes in demand. But this proposal creates a new federal bureaucracy with price control authority. Also, it is unacceptable that no place has been reserved on the board for a physician or AMA representative.

THE PRESIDENT'S PROGRAM	AMA'S RESPONSE
State Responsibilities	
States • by 1 1 97 must establish at least 1 alliance and assure all eligible individuals enroll • certify health plans to participate in alliances • ensure the availability of a plan priced at or below weighted-avg premium • submit to National Health Board plans to regulate health plans, administer data collection and quality management improvement • may establish a single payor health care system complying with benefit package and cost sharing requirements, or a single-payor alliance for part of a state	The AMA strongly opposes the establishment of a single payor health care system, whether on a state or national level as part of national health system reform legislation No centralized decision making authority can control costs and ensure adequate access to quality services, especially in health care When for good reason the national plan rejects a single payor system nationally, allowing a state to subject its residents to such an unreasonable approach is contradictory and makes little sense
Health Alliances	
Health alliances act as conduits between health plans and individual purchasers of health insurance coverage contracting with health plans to provide the required benefit package and providing a simplified uniform means for individuals to choose between plans Alliances • must contract with a plan unless its premium exceeds the weighted avg premium by more than 20% its quality is poor, or it discriminates • must use risk adjustment mechanism to account for enrollment variations across plans • may be a nonprofit corporation or state agency but nonprofit s board must equally consist of consumers and employers whose selection is determined by the state • must establish provider advisory boards • must enroll all eligible individuals and have annual open enrollment periods • may not bear insurance risk • must publish consumer info on cost, providers, access restrictions, and quality of plans Alliances must offer at least 1 any-willing-provider fee-for-service plan, but may limit number to 3 through competitive bidding National Health Board may waive requirement if not viable or insufficient interest After collective provider negotiations alliance sets provider fee schedule for each fee-for-service plan and providers may not balance bill States may impose prospective budgeting on fee-for-service plans Corporate alliances must also offer at least 1 fee-for-service plan	The AMA is adamantly opposed to the plan s restrictions on fee-for-service True fee-for-service gives individuals the freedom to choose health care services By establishing a fee schedule and barring physicians and patients willing and able from agreeing to the cost of their medical care, true choice no longer will exist in the US health care system Physicians and patients will find it difficult to use choice to guard against health care decision making made at corporate and bureaucratic levels thus diminishing the ability of physicians to advocate for their patients If a health alliance acts as an impartial conduit between health plans and purchasers, acting to make it easier for individuals and small businesses to make insurance purchases and encouraging competitiveness between health plans, health alliances can help bring about needed fairness in the health insurance market If an alliance cannot act fairly, true competitiveness cannot be assured Alliances should be required to accept all fee-for-service plans offered instead of limiting the number to 3 True freedom-of-choice for individuals to determine what kind of health care delivery best meets their needs is severely diminished Plans should be encouraged to recognize the RBRVS for determining physician reimbursement using individual physician selected conversion factors Plans should authorize individuals to contract for any health services they want with their own after-tax funds
ERISA	
• Corporate alliances subject to new fiduciary/ enforcement requirements regarding national benefit package plan info requirements and uniform data claims electronic billing and grievance procedures • Self-funded plans must set benefit payment trust fund, beneficiaries receive special protection in bankruptcy if employer fails • National guaranty fund established • ERISA preemption of state laws modified to apply only to corporate alliances allow nondiscriminatory taxes on them, allow state-all payor rate setting allow states to include corporate alliances to reimburse essential community providers	AMA has long supported ERISA reform The plan proposes to address many of the problems identified by the AMA that have developed under ERISA including protecting beneficiaries of self insured plans from unfair coverage decisions and plan insolvency Such changes have long been needed to ensure that all Americans are treated fairly by those who insure their health benefits, whether an employer or an insurance company However ERISA s preemption of state law should not be amended to authorize a state single payor system to apply to large employers or to allow varying reserve requirements from insured plans within the state
Health Plans	
• Health plans must accept all eligible individuals have an open enrollment period and may not cancel reduce benefits even for enrollee nonpayment Pre-existing condition limits and disease-specific exclusions are prohibited • Each August alliance negotiates premium rates with each plan and publishes rates Employer employee pay community rate Alliance adjusts payments to plans based on risk adjustment formula set by national health board Plans with high risk populations may remunerate • Plans must provide alliance with extensive info on cost quality provider availability DR consumer rights and plan responsibilities • Plans must provide consumer info on risks benefits medical procedure costs and advance directives Grievance procedures and alternative dispute resolution required • State laws protecting against managed care abuses are preempted • State laws banning the corporate practice of medicine are preempted • The ability of plans to own facilities or offer medical services is authorized • Out-of-service area emergency urgent care required paid on alliance s fee-for-service payment schedule • A plan must have advisory boards of providers selected by providers which must be consulted frequently and has access to plan information • Loans are available for community-based plans	The insurance reforms offered in the President s plan are important elements of health system reform Setting premiums based on community rating and eliminating pre-existing condition exclusions have long been urged by the AMA Health Plans should be required to create a committee of practicing physicians within the plans that is responsible for establishing clinical decision criteria Exceptions to community rating should not be granted to large firms Establishing a system of shared uniform information about plans through the alliances will help consumers make informed insurance purchasing decisions Nevertheless provisions that would preempt laws that states have enacted to protect against abuses in managed care need to be eliminated The President s plan overall give such a strong encouragement to managed care that states need to be allowed to continue their authority to act when abuses occur The plan should not override state corporate practice of medicine laws in states that currently prohibit such Further, managed care plans should be required to accept any physician who meets stated credentials and who agrees to provide services under an agreement with the plan and subject to plan capacity

THE PRESIDENT'S PROGRAM	AMA'S RESPONSE
Global Budgets/Price Controls The plan describes a national health care budget based on the weighted avg premium for the guaranteed benefit package as a two-tiered backstop to market action. The target increase in premiums for 1996 is CPI + 1.5, CPI + 1 for 1997, CPI + 0.5 for 1998, and CPI for 1999 and beyond. A national per capita based premium is set by the national board, as is a system to adjust at alliance level for risk factors like age demographics. (Programs for Alliances then receive an avg premium from the national board. Plans submit bids to alliances either blind or with knowledge of the target. Alliances then submit their negotiated premiums to national board, which tells the alliance if its avg premiums is acceptable or not. If not, the alliance renegotiates. If the alliance exceeds its target, there is a 2-yr recoupment. Targets may not be adjusted, except by Congress. Corporate alliances use an equivalent target and are terminated if they miss target 2 out of 3 yrs.	The AMA staunchly opposes the setting of any national budget. Any decision-making in health care based mainly on economics and not on patient needs is not in the best interests of patients and will lead to rationing that cannot address the difficulties and inequities in our current health care system. This issue will be a key area of concern and activity in the coming months as health system reform continues in Congress. The President's plan calls its spending limits "targets." The AMA believes that a participatory process that includes physicians might be useful to establish true goals that can be flexible and are based on patient needs. As written, though, these "targets" are stringent, arbitrary caps on spending. This is fully unacceptable.
Administrative Simplification • National board must develop simplified forms. By January 1995, UB92 must be used for institutional services; standard health insurance claim form similar to HCFA 1500 for noninstitutional, HCFA 1500 for dentists, and universal drug claim form for pharmacies. • National board must set automated transaction and coding standards. Private payors must adopt electronic data interchange (EDI) standards by 1/1/95; federal programs ASAP after enactment. Providers, including medical groups of over 20, must automate within 6 mos of standardization. States can deny payment to plans not using EDI. • Medicare simplification: contractors will be consolidated based on function, not area; balance billing for DME eliminated; national data file on Medicare beneficiaries created; and Medigap terminations take place as part of national data file; presumptive waiver of co-insurance with physician's acknowledgement; physicians input in carrier performance. Parts A and B claim processing integrated; attestation requirement eliminated except for hospital medical staff privileges; pre-approval for 10 surgical procedures eliminated; system changes more than once every 120 days prohibited. PROs must focus on patterns, not individual cases. • The health security cards all individuals receive is like an automated teller machine, to be used to access a national uniform health data set established by the national board. • Unique identifiers to be established for plans, practitioners, providers, and patients. • An information system is envisioned that will be able to collect data from all encounters, using a standard format with an emphasis on electronic records. Encounter data is to be transmitted to regional information network, to be used to set national info trends. A national data advisory committee for research is established.	AMA supports forward movement in electronic data management that will lead to patient care improvements, but such changes should not solely be predicated on cost savings. While administrative simplification is necessary to help contain health care costs, certain specifics of this proposal may prove unsatisfactory if not implemented in the best way. Where the private sector is capable of bringing about simplification, government should not duplicate those efforts. We are concerned that the national board will set standards for coding systems when AMA's CPT coding is already used for coding throughout the health care industry. The national board should recognize this achievement, which is the result of a long cooperative relationship between the private sector and government. We are also concerned that, while private payors are given the responsibility for adopting EDI standards, a time limit is set for its adoption. We are fully confident that the private sector is developing and quickly integrating EDI without government involvement. No new unique identifiers should be created by the government. Physicians already are identified by Medicare/Medicaid UPIN numbers, and SPIN is already widely accepted in sectors of the industry. Accepted identifiers need not be duplicated. As with other EDI issues, assuring patient confidentiality will continue to be a goal of the AMA. There should be no micro-management of the information system at the national level. The costs of developing any information management systems should be kept to a minimum and not shifted. Confidentiality must be assured.
Quality • A national quality management program is set, to be overseen by a 15-member advisory council to the national board, consisting of consumers, plan reps, states, and public health and quality experts. National performance goals, minimum standards, research support, and a report on quality are required. Advisory council must set national program to develop practice guidelines, scientific standards and priorities. • Program is "customer-focused," based on consumer satisfaction and outcomes. Plan info collected by alliances is to be used to compare plans. Program publishes results of all plans annually. Regional data centers created. States enforce standards. • National regulation preempts local regulation; intervention must focus on problems, with targeted reviews and randomly selected validation sites; demo program required by 1/1/96. • Medicare PROs continue until HHS determine they are no longer necessary. • NIH funding expanded for effectiveness and outcomes based on quality, with a program to evaluate reform and program to study how consumer choice and decision-making take place.	AMA recommended a comprehensive program that would recognize the profession's well-established accrediting and quality assurance programs. The AMA is deeply concerned that physicians have not been included specifically in the advisory council that will be responsible for so many initiatives in quality, especially the establishment of practice parameters. We will work to ensure that such efforts continue to be led by the profession. We are hopeful that HHS will quickly come to the conclusion that Medicare PROs are not cost effective.
Scope of Practice Scope of professional practice continues to be based on state laws. However, HHS must develop and encourage state adoption of a national model professional practice statute for advance practice nurses and physician assistants. States may restrict the practice of health care professionals only on the basis of competency.	The AMA opposes any federal efforts to duplicate or supplant states' responsibility to ensure their residents' health and safety through national professional practice standards. States are in a unique position to react to their specific health care needs and deciding the appropriateness of professional practice is a key means of assuring the safety and quality of health care in a state. Federal standards must not supplant state authority or criteria.

THE PRESIDENT'S PROGRAM	AMA'S RESPONSE
Physician Workforce	
• After 5 yr transition, 50% of physicians in training must be in primary care. Phase in requires primary slots each yr to increase 7% and specialty slots to decrease 10% • HHS allocates positions based on recommendations of new national council on graduate medical education. National council allocates positions to regional councils which distribute positions to programs. Allocations based on program quality, relevance of training programs to actual practice, minority representation, and participation of locally coordinated plans. Programs with more slots than assigned receive no national GME funding. HHS has veto over allocations. Allocations good for up to 3 yrs • National council members must include educators, practicing physicians, hospital administrators, program directors, nurses, others. Views of national professional associations must be sought. Regional councils include reps from health alliances, teaching programs, consumers • **Financing**: insurer and Medicare pooled GME funds ($6 billion) are made to programs, not institutions, to encourage out-of-institution programs. Transition payment made to hospitals that have reduced positions to replace residents with other staff, beginning at 150% of avg resident amount in first yr • Primary care incentives: primary practice loan forgiveness, development of primary care retraining, special emphasis for minorities and community training at undergraduate level and continuing medical education, double training positions for nurse practitioners, nurse midwives, and physician assistants, special emphasis is for mental health substance abuse prevention, geriatrics, school-based health care, community care, and managed care • Medicare primary care incentives: reduce payment rates for office consultations with savings transferred to increase reimbursement for office visits, increase office visit RVUs to cover pre- and post-visit time and reduce RVUs for all non-primary care services to maintain neutrality, resource-based overhead component, increase primary care MPVS for primary care to GDP per capita + 5% in 1995, increase 10% bonus for nonprimary care in urban shortage areas and double bonus to 20% for primary care in all shortage areas, reduce outlier intensity procedures	The program would federalize the nation's system of medical education. While more primary care physicians are needed, the AMA opposes arbitrary quotas restricting individuals' free choice to pursue their chosen fields. The reasons some physicians do not choose primary care are complex and involve lifestyle, practice environment, educational background, future income and meeting personal goals based on individual interest. So a multi-faceted approach to stimulate interest is needed. Federal centralized decision-making will not guarantee an adequate supply of primary care physicians. Allocations are best made based on local needs and institutions' ability to provide an acceptable educational experience. While the idea of a national council may have some merit, it should be advisory in nature and its composition reflect those knowledgeable about medical education. Regional councils predominantly made up of physicians could be established to make advisory recommendations. The size should not be excessive; regional health planning bodies with wide representation demonstrated the political nature of such groups resulting in ineffective function. HHS should not have veto power. Regional council decisions should be advisory. AMA opposes: • differential payment to programs based on specialty • the use of accreditation bodies to rank programs by quality, the concept is not yet developed sufficiently to be effective • federal prohibition of independent funding of GME positions; changes in need for physician training may require flexibility in seeking funding • allocating funds to individual programs, which would fragment the system and create a large, inefficient bureaucracy; allocation of funds to consortia that include medical schools would provide more effective coordination and evaluation of programs • RBRVS should not be manipulated to achieve allocation goals
Academic Health Centers	
• Medicare funds and a surcharge on private health plan premiums ($6 billion) are to be collected as a fixed percentage add-on to help academic hospitals • Medicare payments to teaching hospitals to compensate for uninsured and disproportionate share are reduced • A national pool is established to support institutional research positions for specialized care • Health plans must cover routine costs of approved clinical protocols and have agreements with academic health centers to care for certain disease or patient populations to assure access to academic health centers. Regional health alliance must monitor	AMA supports assistance to academic health centers based on the additional costs of providing tertiary care. AMA also supports the requirement that plans have an agreement that ensure access to academic health centers when needed. Special attention must be given to the transition period until an entire system of health care reform is implemented, so that elimination of disproportionate share funding for indigent care does not create excessive hardship.
Public/Preventive/Rural Health Initiatives	
• NIH funding for prevention and health research services are expanded • With universal coverage, public health depts can do data collection, surveillance, environmental protection, housing, food/water supply, epidemiology, monitoring, emergency response. State formula grants established • States encouraged to develop effective health education programs to assure proper licensure, training, community focus • Alliances can sponsor plans in rural areas • Rural health professional incentives include nonrefundable personal $1000/mo tax credit for physicians ($500/mo for nurse practitioners and physician assistants), NHSC loan paybacks excluded from income, $10,000/yr tax allowance for equipment purchased in HPSA, student loan interest deduction up to $5000/yr	The AMA has long called for these kinds of incentives, especially in rural areas. Similar initiatives in currently underserved urban areas must not be ignored.
Workers' Compensation/Auto Injury	
Health plans provide treatment for medical services under workers' compensation and auto insurance policies and are reimbursed at negotiated fee-for-service alliance schedule with no copayments. States must determine workers' compensation benefits. Under workers' compensation, state freedom-of-choice provider laws are preempted.	The AMA opposes the preemption of state freedom-of-choice provider laws under workers' compensation. Without such laws, workers will be forced to see physicians who will not be their personal physician. Continuity of care, and thus quality of care may be seriously challenged.

THE PRESIDENT'S PROGRAM	AMA'S RESPONSE
Supplemental Insurance Two types of supplementary insurance are allowed -- beneficiary benefit supplemental insurance and cost sharing supplemental insurance. Only plans that have high cost sharing options may offer both. Only high cost sharing can offer supplemental cost sharing insurance. Added benefits supplemental insurance may not duplicate coverage; community rating generally required; no exclusions allowed. National health board regulates.	The AMA supports consumer protections for supplemental insurance similar to those now established for Medigap. The plan should recognize the expertise of state insurance commissions and the NAIC. The AMA objects to a centralized national board approving all supplemental policies. Freedom-of-choice requires that the government not restrict the availability of supplemental policies as long as consumer protections are maintained.
Clinical Labs • Inspections required for labs performing 50,000 or more tests per yr. that does critical testing where answer needed quickly, where erroneous results would lead to serious harm, where testing done to monitor care. • Exempt labs doing waiver tests/microscopic tests no longer have to register or be involved at all. • Limited license practitioners allowed to be added to microscopic category. • More tests added to waiver category. • Existing personnel grandfathered. • Proficiency testing education, with action only if extremely poor. • Study to modify the cytology proficiency standard. • In portion focus shifted from all labs to high risk labs. • Announced inspections are under review.	The AMA believes that the CLIA program is a costly bureaucratic burden and should be repealed. But if CLIA must continue, these provisions are consistent with changes the AMA believes are necessary and has been working to bring about.
Long-Term Care Home and community care program for all ages included in benefits package. States may design their community based services system. Sliding-scale co-insurance required. HHS sets a national budget for home and community based services and allocates funds to the states; annual increases generally the same as national budget.	Again, placing a national budget on health care services is not acceptable. Further, the need for long-term care services will not be fully met unless a program is established to finance all long-term care services, not only home and community care. Due to the custodial nature of such services, these issues should be addressed separately.
Liability Reform • Patients must submit claims through an alternative dispute resolution (ADR) system each health plan must establish using models developed by national board. Complaint may be pursued in court after ADR. • Suits must include certificate of merit affidavit signed by medical specialist in field relevant to claimed injury that care deviated from established standards. • Attorneys' fees limited to 33 1/3% or lower state limit, if imposed. • HHS must set rules for public access to info contained in National Practitioner Data Bank. • Collateral source rule: recovery amounts must be reduced by amount received from other sources. • Either party may request awards to be paid in periodic installments. • State enterprise liability demonstration projects receive federal funds. • HHS authorized to develop pilot program to test effectiveness of using practice guidelines adopted by the new national quality management program, which is an expansion of the new Maine experiment. Physicians demonstrating compliance with guidelines not liable. HHS may work with states to invest practice guidelines with the force of law in pilot program.	The President's plan has not met the need to address the continuing liability crisis in health care. AMA proposed detailed initiatives similar to actions taken in California under its MICRA law are needed to deal with the high costs that excessive litigation and awards will only continue in the future, including a $250,000 limit on noneconomic damages and more stringent limits on attorneys' fees. Setting the limit on attorneys' fees at 33 1/3 percent is no limit at all, since this is the typical share of awards that attorneys take from their clients now. We are also concerned that health plans and not states are responsible for establishing ADR programs; such responsibility should be given to an impartial state authority. The AMA is also opposed to enterprise liability, since it does not address the costs of the liability crisis, only shifts who pays for liability premiums. Providers following clinically relevant guidelines developed by professional associations should be allowed to raise such compliance as an affirmative defense in liability actions.

THE PRESIDENT'S PROGRAM	AMA'S RESPONSE
Antitrust Reform	
A Small hospitals may merge. DOJ/FTC must publish guidelines providing safety zones for hospital mergers and joint ventures, including the analysis used and expedited reviews and advisory opinions B DOJ/FTC must publish guidelines providing safety zones for physician network joint ventures with less than 20% market share and that share financial risk with examples of acceptable ventures; expedited business review or advisory opinion procedure. **Within the safety zones, physicians may bargain collectively with health plans about payment, coverage, decisions about medical care, and other matters without fear of federal enforcement of the antitrust laws.** C During transition, physicians other provider allowed to negotiate with health plans; narrow safe harbor established to negotiate prices if they share financial risk (but not only fee discounting); physicians providing benefit package services may combine to establish or negotiate prices if they share risk and their combined market share is less than 20%. These safe harbors do not apply to implicit/explicit threat of boycott D DOJ/FTC must publish guidelines for applying state action doctrine, where states grant antitrust immunity to hospitals/institutions E DOJ/FTC must publish guidelines describing under existing law providers' ability to collectively negotiate fee schedules with the alliances F Health insurers' anti-trust exemption under current law is repealed so they no longer can collectively determine their rates	These provisions are insufficient in letting physicians compete in what will be, under this plan, a health care system dominated by large corporate managed care entities. Provisions must be included to allow physicians to collectively negotiate with these large entities as well as for the AMA and other societies to negotiate on behalf of physicians A Allowing small hospitals to merge may allow them to have dominant market power in most communities. Further consolidation will only enhance this control and provide far too much leverage over physicians in negotiations B Guidelines for physician network joint ventures may be useful. AMA has proposed detailed guidelines for safe harbors for physician networks. Clear-cut examples are needed, including efficiencies associated with clinical patient management using practice parameters, referral protocols. Formula for calculating physician market share also needed C A carefully crafted definition is needed for financial risk sharing, e.g., accepting capitation contracts, contracts with fee withholds related to utilization goals, and investing equity interest in the network itself D The state action doctrine should be more broadly written E Useful F Useful
Fraud and Abuse	
A DOJ/HHS jointly coordinate federal/state/local fraud and abuse law enforcement activities. B Current Medicare/Medicaid anti-kickback statute expanded to all payers; civil monetary penalties added; exceptions to include at-risk payments, all "downstream" payments made to provider in at-risk plan C All self-referrals prohibited, except on at-risk basis D Federal authority is expanded to include forfeitures of fraud proceeds and new law modeled after existing mail and bank fraud law, including $10,000 civil monetary penalties E Medicare exclusion provisions apply to all health plans. F Standard of knowledge is "knows or should know."	A Support efforts that are comprehensive to combat fraud in public and private sectors, don't extend HHS IG authority or civil money penalties to private sector. FBI/DOJ ok B Appropriate for criminal penalties for intentional kickbacks for all payers C Generally support ban on self-referrals, but need exceptions in situations where there is a demonstrated community need and where alternative financing unavailable D Forfeiture of proceeds of fraud ok, but not RICO confiscation. Support bank-fraud model E Exclusion procedures should apply to all payers for criminal convictions except in cases where loss of provider would put patients at risk of no access. The HHS Secretary should not be authorized to exclude providers from private plans unless there is a criminal convictions or their is an immediate and grave risk of harm to patients. Otherwise, the Secretary could deny a livelihood for failure to comply with various Medicare/Medicaid rules F Standard of knowledge should be "intent to commit fraud" so that honest errors without criminal intent are not handled as criminal matters
Medicare/Reductions in Reimbursement	
A States may integrate Medicare beneficiaries into alliances if coverage is same or better. Alliances must offer at least 1 fee-for-service option offering Medicare B Individuals may remain in alliance upon reaching age 65 C Payment methodology to increase payment under the Medicare managed care program. D By 7/1/96 Medicare will cover outpatient prescription drugs under Part B, with $250 deductible, 20% co-pay, capped at $1000/yr. Drug manufacturers must sign rebate agreements for difference between retail/non-retail markets. Reimbursement set at 90th percentile of actual charges	A,B The AMA supports Medicare as a secondary payor, but beneficiaries should not be forced into other coverage situations. If the alliance would impose limits on access to physicians or other providers, beneficiaries should be apprised of this situation and have the opportunity to keep existing Medicare coverage C Medicare now gives a higher level of coverage for care provided through a managed care entity. If care is equal, so should coverage and fee-for-service should be given parity D The AMA supported drug coverage added as part of the Medicare Catastrophic Coverage Act. The primary AMA concern was patient access to the complete range of drug/biological segments. HHS should not be allowed to limit such access to certain drugs

THE PRESIDENT'S PROGRAM	AMA'S RESPONSE
• Reductions in reimbursement	**Reductions in Medicare reimbursement are unacceptable. Not only are these savings inadequate to finance health reform, they will sacrifice Medicare beneficiaries access to care. The cuts as proposed will continue the tradition of cost shifting Medicare costs to the private sector.**
E Delete volume and intensity from MVPS formula	E Oppose. Eliminating volume and intensity from the MVPS formula presupposes that these factors are never legitimate occurrences. It would penalize physicians for program growth beyond their control.
F Establish cumulative expenditure goals for physician expenditures	F Unclear. If this would prevent annual MVPS rebasing, it would be at odds with the original intent to base, in part, annual updates on actual expenditures.
G Reduce Medicare fee schedule conversion factor by 3% in 1996, with primary care services exempt	G Oppose. This is another arbitrary reduction in Medicare that has no relationship to any likely reduction in the cost of providing care.
H Establish prospective payment for hospital outpatient radiology, surgery, and diagnostic services	H Oppose. Setting related physician services on a prospective basis places all economic incentives against patients. The AMA has long opposed prospective payment for physician services.
I Reduce Hospital Market Basket Index update by a further 0.5% in 1997 and 1% in 1998-2000	I Oppose. The AMA historically has opposed hospital updates below the market basket.
J Reduce IME Adjustment to 5.65% in 1995 and 3.0% in 1996 and thereafter	J Oppose. The AMA has supported a 0.7 reduction in the 7.7% IME adjustment, with a follow up study to determine a payment amount and equitable accounting methodology.
K Reduce hospital inpatient capital payments	K Unclear. The AMA supported the OBRA-93 extension of the current 10% reduction in payments for the capital-related cost of outpatient hospital services which previously applied through FY 1995, through FY 1998. We generally support reasonable payments for hospital capital expenditures.
L Phase-down Disproportionate Share Hospital adjustment by 1998	L Unclear. This adjustment may become increasingly unnecessary if Medicare acute care coverage is shifted from state Medicaid programs to alliances.
M Expand centers of excellence	M Unclear. While the AMA recognizes that such centers naturally develop efforts to arbitrarily establish a center can overlook existing capabilities and may stifle competition that actually serves to increase access to care by decentralizing care sites.
N Lower home health cost limits to 100% of median by 7/1/99	N Unclear. However, by shifting payment for these services based on a national median overlooks the highly labor intensive nature of the care provided resulting in overpayment and underpayment for these services based on where the care is provided.
O Competitively bid for all Part B lab services, except in rural areas, and other Medicare services	O Oppose. Medical services, including clinical lab services, are highly personal, and do not lend themselves to competitive bid. Patients should not have options for these services limited based on price, as opposed to quality.
P Extend Medicare Secondary Payor Provisions for ESRD patients	P Support
Q Increase Part B premiums for individuals with income above $100,000 and for couples with incomes above $125,000	Q Support
R 10% coinsurance for home health visits more than 20 days after discharge, 20% coinsurance for lab services	R Support. Medicare payment of the 20% coinsurance for lab services was enacted as a quid pro quo for requiring that these services be furnished strictly on an assigned basis. With application of coinsurance for these services, the mandatory assignment requirement should be lifted.
S Subject all state/local employees to HI tax	S Support
T Set Part B premium into law	T Unclear. The AMA has supported an income- sensitive Part B premium and maintaining payment levels for the premium at a level to achieve at least the current 25% of costs for aged beneficiaries. (Without a change in current law, premiums would decrease in 1999.)
Tax Subsidies	
Employer contributions toward premium/cost sharing of benefit package are tax deductible to the employer and not counted as income to the employee. When alliances are established, tax deduction is allowed only if contribution is made through an alliance. Benefits exceeding benefit package are taxable to the employee; but if benefits provided as of 1/1/93, tax preference allowed for 10 years.	AMA supports a cap on the tax advantages placed on health insurance premiums. Such a cap establishes a limit on tax support, but continues to allow individuals the right to seek additional coverage with their own after tax dollars. Such a cap will improve consumer decision making since expenditures beyond the cap are not subsidized.

The CHAIRMAN. Linda Shinn.

Ms. SHINN. Good morning. Mr. Chairman and members of the committee, I am Linda Shinn, the interim executive director of the American Nurses Association. We very much appreciate this opportunity to discuss President Clinton's health care reform proposal.

I would like to summarize my statement and ask that a copy of my complete remarks be entered into the record.

The CHAIRMAN. It will be so included.

Ms. SHINN. Thank you.

The American Nurses Association is the only full-service professional organization representing the Nation's 2.2 million nurses. We are pleased and proud to support the Clinton administration's health care reform proposal.

My remarks today are also on behalf of the following organizations: the American Association of Critical Care Nurses, the American Association of Nurse Anesthetists, the American Association of Colleges of Nursing, the Association of Operating Room Nurses, the Emergency Nurses Association, and the National Nurse Practitioner Coalition.

Mr. Chairman, we commend you on your leadership in health care reform, and we were proud to support S. 1227 in the 102nd Congress, one of the first steps in this very important process. And we thank you for your particular attention to nursing's issues throughout your leadership with this committee.

America's 2 million registered nurses deliver many health care services in the United States today in a variety of settings—in hospitals, in nursing homes, in schools, in home health agencies, in the workplace, in community health clinics, in private practice, and in managed care settings. Nurses know first-hand of the inequities and problems with our Nation's health care system. Because we are there 24 hours a day, 7 days a week, we know all too well how the system succeeds so masterfully for some and yet continues to fail so shamefully for all too many others.

Like President and Mrs. Clinton and so many members of Congress, America's nurses believe it is time to frame a bold new vision for health care. For the last 5 years, nursing has worked to develop a plan which encompasses the profession's best vision for a health care system for the future. There are several key features of nursing's agenda for health care reform that are very similar to provisions contained in the President's American Health Security Act.

Like the administration, nursing believes that universal access to health care services is a principle that cannot be compromised. Their proposal would ensure that health care would be available everyone—the uninsured, the underinsured, and the potentially uninsured. For any health care reform plan to be successful, it is critical that it address not only access to health insurance, but also access to health care services. Under the administration's proposal, the health care setting could be restructured and reoriented so that services would be available in schools and in workplaces and in community settings, as well as in hospitals and in providers' offices. Consumer access to health care services in this process must be maximized.

A cornerstone of nursing's agenda for health care reform has been the guarantee of a standard health benefits package. This is a critical point of our agreement with the administration plan which places new emphasis on primary care and preventive services delivered not only by physicians, but also by nurses and other qualified providers in convenient, accessible settings.

We do, however, have some concerns about the mental health benefits package, the full integration of long-term care in a reformed health care setting, and the schedule of screenings that are proposed for reproductive health cancers.

The expanded role of nurses in a reformed health care delivery system is apparent throughout the President's proposal. It is an important element of the plan's emphasis on preventive health services, which have been the center for nursing practice since the inception of the profession many, many years ago.

However, the ability of nurses to provide health care services has been continually hampered by a number of artificial barriers that serve to cut the consumer off from access. These barriers include restrictive reimbursement policies and State restrictions on nursing practice.

The President's plan addresses this problem by preempting barriers to practice, providing States incentives to adopt a Federal model for nursing practice statutes, and by including payment for services of advanced practice nurses, such as nurse practitioners, certified nurse midwives, and clinical nurse specialists.

Consumers have shown their widespread acceptance of these services and their willingness to continue receiving primary care services from nurses. A very recent Gallup poll revealed that the vast majority of Americans, some 86 percent, are willing to receive many of their everyday health care services from advanced practice registered nurses that they now usually go to a physician to receive.

As the focus of the health care delivery site has shifted from acute care institutions to community-based care, there has been and will continue to be an increase of hospital mergers and hospital closures resulting from oversupply of beds. While we acknowledge that this change is inevitable, we have been working closely with the Department of Labor and the White House on their work force proposals in the health care reform plan, and we commend the Department of Labor for developing an initiative that provides assistance to workers before they potentially become unemployed.

Critical work force issues are raised by the health care reform plan and its effect on employment. Registered nurses are the Nation's single largest group of health care providers, and many of them will need to be retrained to appropriately staff a new, revised health system. It is essential, we believe, that a retraining and redeployment plan be designed to facilitate that transition. That transition is critical, and a transition plan is outlined in the statement that has been submitted for the record.

Nursing commends the administration and this committee for its focus historically on nursing education issues. Funds are needed as well to support the education and training of primary care nurses, including in rural areas. We also applaud the administration's proposal to expand the Nursing Education Act. Nursing shares as well

with the administration and this committee a commitment to increase the cultural diversity of the health care work force by supporting programs aimed at underrepresented ethnic minority and/or disadvantaged persons.

Mr. Chairman and members of this committee, thank you for this hearing and for your diligent efforts to find solutions to the health care crisis. We appreciate this opportunity to share our views with you and look forward to the continuing work ahead as all of us move toward comprehensive health care reform.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Ms. Shinn follows:]

PREPARED STATEMENT OF LINDA SHINN

Mr. Chairman and members of the Committee. I am Linda Shinn, MBA, RN, CAE, Executive Director (Interim) of the American Nurses Association (ANA). Thank you for inviting us to testify today on President Clinton's health care reform proposal.

The American Nurses Association is the only full-service professional organization representing the nation's two million registered nurses including staff nurses, nurse practitioners, clinical nurse specialists, certified nurse midwives and certified registered nurse anesthetists. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by working closely with the U.S. Congress and regulatory agencies on health care issues affecting nurses and the public.

Access to high quality, affordable health care is of concern to millions of Americans—not only to the over thirty seven million who are uninsured, but to the growing number of currently insured who fear that changing or losing their jobs will result in loss of coverage or that skyrocketing costs will make their dependent's coverage or their own out-of-pocket health care costs unaffordable.

We are also testifying on behalf of the:

- American Association of Critical Care Nurses (AACN), the largest specialty nursing association in the United States with over 73,000 members who are dedicated to the welfare of people experiencing critical illness or injury. AACN has pledged its strong support of the Clinton Administration's health care plan;
- American Association of Nurse Anesthetists (AANA), the professional society that represents over 24,000 certified registered nurse anesthetists (CPNAs), which is 96 percent of all nurse anesthetists who practice across the United States. AANA's Board has voted to support the Clinton Plan;
- American Association of Colleges of Nursing, with over 432 members offering baccalaureate, master's, and doctoral nursing education;
- The Association of Operating Room Nurses, Inc., the professional organization of perioperative nurses dedicated to enhancing the professionalism of perioperative nurses, promoting standards of perioperative nursing practice to better serve the needs of society and providing a forum for interaction and exchange of ideas related to perioperative health care;
- Emergency Nurses Association, the voluntary membership association of over 21,000 professional nurses committed to the advancement of emergency nursing practice; and
- National Nurse Practitioner Coalition, a group of nurse practitioners who advocate for universal access to basic health care and the removal of barriers to consumer access to nurse practitioner care.

Mr. Chairman, we commend you on your leadership on health care reform and we were proud to support S. 1227 in the 102nd Congress as one of the first steps in this process. We thank you for your attention to nursings' issues throughout your leadership with this Committee.

America's two million registered nurses deliver many essential health care services in the United States today in a variety of settings—hospitals, nursing homes, schools, home health agencies, the workplace, community health clinics, in private practice and in managed care settings. Nurses know firsthand of the inequities and problems with our nation's health care system. Because we are there—twenty-four

hours a day, seven days a week—we know all too well how the system succeeds so masterfully for some, yet continues to fail shamefully for all too many others.

Nurses see people on a daily basis who are denied or delayed in obtaining appropriate care because they lack adequate health insurance or are unable to pay for care. These people often postpone seeking help until they appear in a hospital emergency department in an advanced stage of illness or with problems that could have been treated earlier in less costly settings or, more appropriately, prevented altogether with earlier treatment or prevention services.

Delayed access to needed care is associated with problems of increased morbidity and mortality as well as countless hours of lost productivity in the workplace. Infants and children, pregnant women, the frail elderly, people with persistent health problems, rural and inner city residents and minorities are disproportionately represented among these most vulnerable uninsured groups. Their complex and diverse needs are not met by the existing system.

Nursing is concerned by the failures in our current health care system. More than 37 million people have no health insurance and millions more are critically underinsured. our health care systems are oriented toward expensive interventions to treat illness, rather than essential health services designed to promote and maintain health. As a nation, we have failed to develop appropriate ways to allocate available health care resources and services. Unfortunately, the burden of the reality of the failures of our health care system are disproportionately felt by vulnerable segments of our nation's population. This includes the very young, the very old, the poor, the illiterate and those who live in rural and frontier communities and low-income urban communities.

Like President and Mrs. Clinton and so many Members of Congress, America's nurses believe that it is time to frame a bold new vision for reform—one that keeps what works best in our current system, but casts aside institutions and policies that fail to meet present and future needs—a plan that addresses the triad of problems that exist in the current system: inequitable and limited access, soaring costs and inconsistencies in quality and appropriateness of care delivered.

NURSINGS AGENDA FOR HEALTH CARE REFORM

For the last three years, nursing has worked to develop a plan which encompasses the profession's best vision of a health care system for the future. To ensure that all areas of specialty practice (i.e., critical care, operating room, emergency nurse, nurse practitioner and other advanced practice nurses, etc.) and unique geographic differences were sufficiently represented in the development of this plan, ANA convened a special task force of nursing experts. They evaluated the current health care system in the United States, as well as those of other nations, and subsequently developed a plan for reform that is uniquely American.

To date, in addition to ANA's state and territorial associations, more than 80 national nursing and health-related organizations have endorsed this proposal for health care reform, entitled "Nursing's Agenda for Health Care Reform".

Nursing defines the health care crisis in terms of the need to restructure, reorient and decentralize the health care system in order to guarantee access to services, contain costs and ensure quality. Fundamental restructuring must occur because patchwork approaches have failed. Health care reform must be comprehensive and not limited to addressing only one or two components of the problem. Nursing's proposal does not define the problem only in terms of the uninsured or underinsured; rather, it addresses the health care needs of the entire nation.

"Nursing's Agenda for Health Care Reform" calls for building a new foundation for health care in America while preserving the best elements of the existing system. Influencing the direction of health care reform is a complex, demanding task. Nurses know, however, that in order to preserve the health and well-being of our country and its people we must make important, fundamental changes in how. where and to whom health care is delivered.

Today, America's two million registered nurses are united in urging that the nation's health care system be cured . . . and cured now. We must reshape and redirect the system away from inappropriate use of the expensive, technology-driven, hospital-based models we currently have. A balance must be struck between high-tech treatment and prevention. It is nursing's belief that the system must emphasize and support health promotion and disease prevention and show compassion for those who need acute and long-term care.

Among the basic components of "Nursing's Agenda for Health Care Reform" are the following:

- universal access for all citizens and residents provided through a restructured health care system;

- a federally-defined standard package of health care services including preventive, pre-natal, well-child, mental health, acute and short duration long-term care services;
- guarantees that coverage is provided for the poor with a plan administered by the states in order to anticipate the health care needs and changing demographics of the population. Elimination and restrictions on co-payments and deductibles for those near or under the poverty level;
- an employer mandate to ensure that all employed persons have access to health insurance with a standard benefits package;
- a shift in focus to provide a better balance among treatment of disease, health promotion and illness prevention such as coverage for immunizations, prenatal care, and health screening which has proven effective in preventing costly and devastating disease (e.g., colorectal and testicular exams, pap smears and mammograms);
- enhanced consumer access to services by delivering primary health care in community based settings. The new system would facilitate utilization of the most cost-effective providers and therapeutic options in the most appropriate settings;
- Steps to reduce health care costs, such as: ensuring consumer access to a full range of qualified health care providers; providing early treatment and prevention services at convenient sites, such as schools, the workplace, and other familiar community settings; reducing defensive medicine and unnecessary practices; controlled growth of the health care system through planning and prudent resource allocation; and elimination of unnecessary bureaucracy and decreased administrative requirements through the use of uniform claim forms and electronic billing;
- utilization of case management for people with continuing health care problems to promote active participation in their care and reduce fragmentation of the health care system;
- provision of long-term care services of short duration and in addition to a program of extended care in order to prevent personal impoverishment. This proposal will require more shared community responsibility for care. It will prevent impoverishment due to extended long-term care needs;
- insurance reforms are required to ensure improved access to coverage, including community ratings, affordable premiums, reinsurance pools for catastrophic coverage and other proposals to assist the small group market;
- access to services are ensured by no payment at the point of service and elimination of balance billing in all health plans.

There are several key features of "Nursing's Agenda for Health Care Reform" that are very similar to provisions contained in President Clinton's "American Health Security Act".

Universal Access

Like the Clinton Administration, nursing believes that universal access to health care services is a principle that can not be compromised. The Clinton Administration proposal would ensure that health care would be available to everyone—including those who are now uninsured, underinsured and those who are potentially uninsured.

For any health care reform plan to be successful, it is critical that it address not only access to health insurance, but also access to health care services. Under the Clinton Administration's proposal, the health care setting could be restructured and reoriented so that services would be available in schools, workplaces and community settings as well as in hospitals and providers' offices. Consumer access to health care services must be maximized. Consumer education must be prioritized to foster increased awareness and responsibility for personal health and self care and to provide a greater capacity for informed decision making in selective health care services. In addition, criteria for outcomes of care should reflect the joint perspective of both the health care consumer and the health care provider.

The plan's emphasis on preventive and primary care services is also crucial, because it means that consumers will have a relationship with a primary care provider including nurses, nurse practitioners, certified nurse midwives, etc., that begins when they are still well—so that disease can be prevented whenever possible and so that the provider will be able to intervene earlier, to minimize the severity of illness.

We commend the Administration's plan for recognizing that there will be a greatly increased need for primary care providers in order to ensure access to care and for addressing this need in a comprehensive manner. The plan calls for increased funding for primary care providers—including advanced practice nurses such as nurse

practitioners, clinical nurse specialists and certified nurse midwives. It also calls for removing barriers to the practice of these advanced practice nurses so that consumers' access to these much-needed services is not restricted.

We applaud these moves because they will greatly assist in achieving the goal of universal access to care. The role of nurse providers is very important to the issues of access to high quality health care. The health care system will need a substantial increase in hours of care of these providers.

We are also extremely pleased to see that the Administration plan has addressed the need for increased access to services in rural areas by creating incentives, including financial incentives for health care providers to serve in those areas. Again, nurse providers can play a key role in treating the newly insured populations under health reform. One of the mechanisms that the Administration is proposing to increase access to health care in rural areas is the expansion of the National Health Service Corps. Nursing applauds the Administration for proposing a 20 percent set aside within this program for providers other an physicians.

As the members of this Committee know, there is a growing trend in this country toward part-time and intermittent employment. Unfortunately, such employment status has often meant foregoing benefits, including health insurance benefits. Women comprise the majority of these part-time employees. Nurses have not been immune to this trend, and nursing associations are very concerned about it. Increasingly, nurses in both full-time and part-time employment are losing their employment benefits including health insurance. We know of registered nurses employed full-time at $ 10.00 per hour and with no health care benefits. Their salary does not permit purchase of individual insurance. Guaranteeing health insurance to all employees is something that is of great importance to nurses both as health professionals and as employees.

Standards Benefits Package

A cornerstone of "Nursing's Agenda for Health Care Reform" has been the guarantee of a standard health benefits package. We are gratified that the Administration's proposal provides a guaranteed package of benefits, emphasizing a broad scope of quality health services, not just treatment of disease. It supports school-based clinics, enhanced services for underserved populations and health education. It includes such critical elements as home-based care and public health initiatives and also takes an important step toward addressing the growing need for better and more accessible long-term care services. In addition, the Administration's package includes such important preventive services as immunizations, screening and prenatal care. It places new emphasis on primary care and preventive services delivered not only by physicians, but also by nurses and other qualified health care providers in convenient, accessible settings.

By including services that are geared toward preventing and minimizing disease, the Administration's plan can save the health care system immense amounts of money and ensure a healthier population. One of the clearest examples of preventive care saving long term costs in the health care system is the provision of prenatal care. Numerous studies have shown that receipt of adequate prenatal care is associated with the improvements in pregnancy outcome, particularly a reduction in the risk of low birth weight infants. Health care costs for newborns is significantly lower for babies with mothers who have had adequate prenatal care. In one study in Missouri, adequate prenatal care during pregnancies resulted in a savings of $1.49 for each extra $1 spend on pre-natal care.

We urge the Committee to act to ensure that full and complete reproductive health services are available to women and that preventive screening services, such as mammograms and Pap smears, be available in intervals that are sufficient to detect disease in a timely fashion. Prevention screening for breast and cervical cancer literally saves thousands of lives. The incidence of breast cancer in the United States approximates 150,000 women per year and about 44,000 of those women will die of the disease. Early detection of breast cancer is important because survival is directly related to tumor size and lymph node status. Small, non-palpable cancers found by screening mammography have a 10-year survival rate of 95 percent. When nodes are involved, the survival rate drops to 53 percent or less. Currently, the majority of breast cancers are detected at this latter stage.

THE ROLE OF THE NURSE PROVIDER

The expanded role of nurses in a reformed health care delivery system, including advanced practice nurses such as nurse practitioners, is apparent throughout President Clinton's proposal. It is an important element of the plan's emphasis on preventive health services—services which have been at the center of nursing practice since the inception of the nursing profession. Nurses are key providers in acute care,

school and community health clinics, in home care, hospice care and ambulatory care, all of which are part of the package of benefits to be available under the President's plan.

Nurses, including advanced practice nurses, are well-positioned to fill many of the current gaps in accessibility and availability of primary and preventive health care services. There are over 100,000 advanced practice nurses with advanced education and training in providing primary care services. As many as 300,000 additional nurses could be prepared to provide such services with additional training.

Virtually every study of patient care provided by providers other than physicians has concluded that these providers can deliver services of the same quality as physicians at lower costs. To meet the estimated additional 64 million nonemergency ambulatory care visits under a universal access health care system, 9,000 additional general and family practice physicians would be required at an office expense of $2.1 million. Alternatively, less than 17,000 nurse practitioners. could provide the same level of services at a similar level of quality for about $1.5 million, a savings of 25 percent.

For example, in Philadelphia, a new model for home care of very low birth-weight infants is run by a group of certified nurse specialists. This project yields the same health outcomes as those generated by physicians, but at an average savings of over $18,000 per infant.

A family nurse practitioner in Washington, Kansas directs a clinic serving the critically underserved, as defined by the Kansas Department of Health and Environment. The physician director of this clinic left in 1986, and the clinic subsequently lost its Federal funding. At this time, the clinic is being leased by a country hospital from a non-profit corporation and has contracted with the advanced practice nurse to run the clinic which includes eight exam rooms and is fully equipped. Since a physician is not on the premises, the advanced practice nurse needs to be eligible for direct reimbursement of her services. As she serves in a rural area, she became eligible for reimbursement under Medicare in 1991. She also works through the Kansas Blue Cross and Blue Shield office, the state Medicaid Bureau, and other private insurers to obtain reimbursement under each of their systems. Currently, in the town of Washington, Kansas, there is only one family physician and only three physicians in the entire county. The nurse run clinic is essential to providing the citizens of Washington, Kansas with health care services.

The Marriott Corporation has a nurse-managed program that administers a multifaceted approach to work site health care including primary, secondary and tertiary care. Marriott estimates that with the services of each nurse, the company saves $250,000 per year in health care costs and lost productivity. Occupational health nurses work as employee advocates handling worker's injuries and collaborating with physicians to make sure injured workers receive appropriate care as well as providing primary and preventive care to ensure workplace safety.

The Department of Labor is currently using registered nurses as case managers for workers compensation cases. The use of registered nurses has enabled the participating states to reduce case backlog and has facilitated earlier rehabilitation and return to work of the injured employees.

In Spencer, Iowa, a program entitled "The Northwest Aging Association's Parish Nurse Project" provides health education, resources and referral to elderly persons and facilitates implementation of volunteers and support groups. These interventions have provided assistance which has allowed 118 of the elderly in Spencer to remain in their homes—a cost savings to both the families and the health care system.

In Chicago, there is a program called the Beethoven Project. This program occupies 10 renovated apartments in a Chicago public housing project which has a high level of poverty and crime. Comprehensive services, such as primary health care, Head Start, and a full-time child care center in addition to drop-in counseling, psychological consultation and care management are provided by the nurse directors.

Nursing centers with nurse practitioners in 17 nursing centers in southern Arizona provide health care to about 6,500 patients each year, including many traditionally underserved and at risk populations (e.g., especially senior citizens, Hispanics, and Native Americans). For a half day each week, the Community Nursing Network sets up health centers in churches, recreation centers, physicians' offices, and retirement communities. Registered nurses manage 25,000 visits each year, performing physicals, treating minor illnesses, and monitoring chronically-ill patients. These programs provide free care for those with no insurance coverage.

However, the ability of nurses to provide health care services has been continually hampered by a number of artificial barriers that serve to cut the consumer off from access to services provided by these competent and qualified health providers. These barriers include restrictive reimbursement policies by Federal and state programs

and private insurers. They include irrational restrictions on nursing practice such as physician supervision requirements by laws and regulations at the state level. We have a Medicare program that denies payment for needed health care services by nurse practitioners or clinical nurse specialists in non-rural areas, including underserved urban areas. The laws regarding reimbursement for advanced practice nurses are complicated and convoluted as to which categories of advanced practice nurses may be reimbursed, in what geographic areas, who may be paid and whether or not collaboration with other health providers is required. They are confusing and complex enough, to carrier, provider and consumer alike, as to provide a barrier to access to these services in and of themselves. In addition, there are state Medicaid programs that deny reimbursement to certified registered nurse anesthetists and many categories of nurse practitioners and clinical nurse specialists, even when they are the only providers willing to furnish services to underserved Medicaid recipients. Laws and regulations in many states put unneeded restrictions on the practice of nurses, including advanced practice nurses, to provide services to patients, to provide routine care and medications, to bill insurance companies, operate a private practice, obtain clinical privileges or admit patients to a hospital.

For example, in Vancouver, Washington, one nurse practitioner provides health screening, immunizations and other services to over 2,000 poor children in five inner-city schools which she visits weekly in her mobile van. In other state such as Illinois, this nurse practitioner could not perform these services, as state law would prohibit her from being directly reimbursed by Medicaid.

Inconsistent state restrictions on prescriptive authority for advanced practice nurses is another barrier to health care and promotes the costly use of an additional provider.

In addition to the general examples of barriers to practice just noted, there are three specific Medicare reimbursement barriers to practice that exist for certified registered nurse anesthetists (CRNAs). First, the current Medicare conditions of payment for anesthesiology services that anesthesiologists must meet in order to be paid for Medicare for medically directing a CRNA, restrict CRNAs from performing all the components of an anesthesia service that they are legally authorized to perform. For example, some anesthesiologists insist on performing the anesthesia induction on all patients themselves, then leaving the CRNA to finish the case. Second, the current Medicare hospital condition of participation for anesthesia services and the Medicare ambulatory surgical center condition of participation for coverage for surgical services restrict CRNA practice by requiring physician supervision of CRNAs. Third, the current Medicare regulation on payment for the services of CRNAs states that if a CRNA and anesthesiologist work together on one case, the anesthesiologist may bill the case as if he/she personally performed it and receive 100 percent of the Medicare payment. No Medicare payment is typically made to CRNA involved in such a case, even if the CRNA was the provider actually administering the anesthesia to the patient.

Nurse managed units within acute care settings are also both cost effective and provide quality care. For example, nurse managed units are proving to be very successful in managing patients being weaned from respirators. In addition, studies have documented the positive outcomes demonstrated by the use of neonatal nurse practitioners with low birthweight infants.

The President's plan would address the problem of artificial restrictions on nursing practice by preempting such barriers to practice, providing incentives for states to adopt a federal model for nursing practice statutes, and by including payment for services of advanced practice nurses. It is our understanding that the Administration plans to shore up these provisions by ensuring that advanced practice nurses do not face exclusion or other discrimination by health plans and by extending Medicare coverage to the services of nurse practitioners and clinical nurse specialists in all settings.

Just as nurses throughout the United States have demonstrated their ability to provide high quality, cost effective and accessible health services, consumers have shown their widespread acceptance of these services and their willingness to continue receiving primary care services from nurses. A recent Gallup poll revealed that the vast majority of Americans (86 percent) are willing to receive everyday health care services from an advanced practice registered nurse that they now must go to a physician to receive. Only twelve (12 percent) percent said they would be "unwilling" to go to a registered nurse. Nurses are currently working with consumer-oriented organizations in order to promote shared principles of health care reform. We are confident that as the American public becomes more familiar with the primary care services that nurses can provide, and as more Americans have an opportunity to receive such care from nurses, that the "unwilling" category will decrease sharply. In fact, we believe that, based on the experiences of advanced prac-

tice nurses in HMO, clinic, and private practice settings, more and more Americans will identify nurses as their provider from whom they select to receive primary care services.

QUALITY ISSUES

As health care reform becomes a reality, hospitals and other health care institutions will experience increasing pressure to contain costs. As the focus of the health care delivery site shifts from acute-care institutions to community based care, there will be an increase of hospital mergers and closures of hospitals resulting from an oversupply of beds. It is anticipated that some hospitals will specialize and others will integrate services such as home health and nursing homes.

Nurses have had an opportunity to experience first-hand what many hospitals do when they face pressure to cut costs. In the last few years, nurses have grown increasingly alarmed at the wholesale reduction in quality of care that many hospitals have initiated in the name of cost-savings and cost-efficiency. Numbers of nurses have been cut and nurses have been laid off. In their place, hospitals have hired unlicensed, semi-skilled personnel, often trained by the hospitals themselves in brief training courses. While the use of unlicensed personnel to assist registered nurses is not new, hospitals in the last few years have greatly expanded the use of these personnel, both in numbers and in the range of functions they perform. This has happened at a time when, due to a number of factors, the severity of illness of the hospitalized patient population has increased significantly. As a result, registered nurses find themselves caring for and supervising care for ever-greater numbers of increasingly sick patients. This has meant a continual downgrading of care for patients, one which poses a real risk to their health and safety while hospitalized.

Many hospitals have openly stated—threatened, if you will—that they will increase the trend toward downward substitution if health care reform is enacted. We consider this not only a threat to nurses, but also to the patients we care for—patients who literally entrust their lives to the hospitals. We believe that hospitals must adhere to strict quality controls if patient care is to be protected. Hospitals should not be permitted to sacrifice patient care in the name of cost efficiency. We have received every indication that the Administration will work to institute mechanisms to protect and ensure safe, quality care both in the long run and in the period of transition to a reformed health care system. These mechanisms will include the development of patient outcome measures as well as, in the immediate period, criteria that monitor changes in hospital staffing and patient care delivery patterns to ensure that patient care is not compromised.

THE HEALTH CARE WORKFORCE

Nursing has been working with the Department of Labor and the White House on their workforce proposals in the health care reform plan. We commend the Department of Labor for developing an initiative that provides assistance to workers before they potentially become unemployed. Nursing supports their concept of developing a National Institute for Health Care Workforce Development in order to have a mechanism to analyze the workforce needs of a new health care system.

Critical workforce issue are raised by the health care reform plan and its effect on employment. Within the health care industry, there will be impacts based on the types of jobs individuals hold. Nurses are the single largest groups of health care providers. It is estimated that fully two-thirds of the nation's registered nurses will need to be retrained to appropriately staff a revised health system. Although we are optimistic that nurse displacement will be short term, it will be essential that a retraining and redeployment plan be designed to facilitate that transition. Nursing believes that the transition plan must include a series of interim quality protections that safeguard patient care and provide for retraining and redeployment of health care personnel. The decision of hospitals and other institutions to significantly alter staffing levels, mix or re-ploy personnel should be guided by several basic principles:

- Advanced public disclosure of the intention to merge, close, or significantly redeploy personnel;
- Involvement of consumers and affected professional personnel in development and implementation of educational programs and other means for redeployment;
- Evaluation and report to health care consumers;
- Analysis of the impact of the redeployment on patient outcomes and other quality care indicators; and
- Assurance that re-deployment plans use professional personnel in accord with licensure laws, educational preparation and assessed competence.

In addition, a national transition plan for the health care workforce should contain, at a minimum:

- Retraining and relocation programs to prepare personnel to assume positions in primary health care, public health, and critical care across a variety of health care delivery settings;
- Use of conversion boards to assess the opportunity for the hospital or institution to be converted to some other use in order to keep the jobs in the community;
- Institution of training programs on "How To Start A Business" and access to small business loans in order to encourage nurses and other providers to establishment small community health care clinics to benefit their communities;
- Pre-notification to providers and the community of any hospital closure or merger;
- Continuation of health and pension benefits for health care personnel;
- Continuation of HIV disability coverage;
- Limits on discounting health care services to prevent cost shifting; and
- Annual public reports about the impact of major institutional changes in staffing levels, mix, or deployment on the quality of care delivered.

The situation of a re-focused health care workforce must be monitored very carefully throughout the transition period and into the enactment of health care reform. Should there be significant increases or changes in morbidity or mortality rates or increases in adverse occurrences (i.e., falls, infections, medication errors) or other indicators of change in the quality of care in hospitals, then more aggressive steps to ensure quality patient care will need to be enacted such as a decertification or fine system for hospitals not complying with quality standards.

We understand that the Administration's health care proposal contains many of these provisions to provide a workforce transition plan for health care personnel. Nursing cautions, however, that training opportunities envisioned for low skilled workers in the health care industry (clerical and administrative support positions) may inadvertently increase the pool of another group of low skilled workers (such as nurses' aides, nursing technicians, nursing assistants). Nursing is concerned that any emphasis on short-term and on-the-job training as well as the use of the term "higher value added health care jobs" without defining such jobs will increase the number of low skilled health care providers. This goal neither meets the health care needs of the nation, or is in the best interest of these workers, most of whom are women. Rather, increasing the pool of professional health care providers is critical.

Another issue associated with a decreasing demand for hospital based nurses is the possible decline in nursing wages. To minimize this downward pressure on wages, the current and future supply of nursing labor must be channeled away from settings with decreasing demand and into high growth areas. To maximize nurses' earnings and avoid serious imbalance in the supply and demand for nurses, a specific plan to systematically assess, manage and evaluate the recruitment, education and utilization of nurses is needed.

NURSING EDUCATION

Health care reform will require a refocusing of knowledge and skills for nursing faculty and future nurses. With greater emphasis on prevention and early intervention, as well as a decreased need for acute care nurses, nursing education will need to be re-focused on primary health care and the management of acute minor illness and complex chronic diseases. Skills in case management, discharge planning, supervision of health personnel, and financial planning will be essential. Fortunately, many nurses are skills in these vital areas, but many more will be needed.

The trend that will occur in a health care reform environment which is of most significance to nurses is the shift in balance between episodic, high cost, specialty focused, hospital based tertiary care to primary and preventive care delivered in a range of ambulatory care settings by a variety of practitioners. This shift is already occurring, as witnessed by the rapid growth in home care and ambulatory care services.

Since World War II, the majority of nurses have been educated for and employed in hospitals. Significant educational efforts on both the part of individual nurses and the health system are now needed to focus on the delivery of primary health care services. The Administration has included several health provider education initiatives in their proposal. Under their plan, the Secretary of Health and Human Services will determine the estimated need of nurse workforce and advance practiced nurses needed to meet the current health care demands of the nation. This will be based on the workforce estimates developed by the National Council on Nurse Edu-

cation and its allocated regional councils. To fund nurse education, new programs need to be established to increase the supply of nurses.

According to the National Sample Survey of Nurses (1988), there are approximately 125,000 registered nurses working in physician offices, freestanding clinics, ambulatory surgical centers, health maintenance organizations and other ambulatory care settings. In addition, there are approximately 11,000 registered nurses working in community/public health settings, 48,000 in school health, and another 22,000 in occupational health. With the appropriate funding support, this pool of generalists nurses could begin to rapidly increase the nation's supply of primary care providers.

Nursing commends the Administration for its increased focus on nurse education issues. It is clear that the United States health care system has an increasingly urgent need for primary care providers. Immediate funding must be made available to strengthen existing advanced practice nurse programs and to establish new programs to prepare the primary care providers so urgently needed.

The Administration's plan would shift the funding emphasis under Graduate Medical Education from specialty physicians to primary care physicians. Advanced practice nurses will be increasingly needed to fill the future gap created in this shift in medical education. For example, a reduction in the supply of physician anesthesiologists will require increased funding to educate a greater number of certified registered anesthetists.

Nursing has specifically recommended that an amount equal to 10 percent of direct Graduate Medical Education (GME) funds be pooled from all insurers and be used in a manner similar to that used in the GME program for physicians. These funds would be allocated to support the education and training of primary care nurses and specialty advanced practice nurses, such as certified registered anesthetists, who will be needed in greater numbers under the Administration's plan by allowing reimbursement of providers for faculty costs and student stipends through GME. This program would enable hospitals to maintain quality service and cost effectiveness within the constrains of the new system. This new program could be funded by a combination of Medicare contributions and a surcharge on health premiums. Because of the importance of advanced practice nurses to the delivery of care, a constant stream of dollars is needed to support the education and training of these providers on a basis similar and equal to resident physicians. Nursing believes that this fund must be in addition to the current Nurse Education Act program.

We applaud the Administration's proposal to also expand The Nurse Education Act for the purposes of retraining nurses to meet the new health care needs of the nation as well as expand the supply of nurses. Increases in the number of graduate programs which focus on primary care as well as increases in the capacity of current graduate funding programs will be necessary under a reformed health care system.

Funds are needed to develop retraining opportunities for nurses who are forced to leave the tertiary care workforce for community, primary and preventive care practice areas including post-master's certificate programs to enhance the primary care skills and abilities of clinical nurse specialists and other master's prepared nurses. BSN programs will need to be expanded to assist the diploma and associate degree nurses employed in acute care settings to rapidly obtain a BSN in order to enhance their community, public health and/or critical care knowledge and skills. In addition, hospitals will need assistance to provide continuing education to acute care nurses for acquisition of community care nursing skills. These BSN assistance programs and continuing educations programs are essential in order to prepare nurses to make the transition from hospital to community based nursing care.

In addition to preparing primary care providers and other nurses, it is also of importance to ensure that there is an adequate supply of nurse educators, both at the undergraduate and graduate levels of education. Existing nursing faculty may need additional training themselves in order to become nurse practitioner and other advanced practice nurse educators.

Nursing strongly supports the Administration's stated intention to increase the cultural diversity of the health care workforce by supporting programs aimed at under-represented ethnic, minority and/or disadvantaged persons. The proposal supports efforts to recruit and retain students to nursing and other professions and to increase the number of minority faculty and researchers in the health professions.

RESURGENCE OF THE PUBLIC HEALTH SYSTEM

Increased funding for public health programs at a state level is critical to the future health and well being of a diverse population. The Administration's proposal coordinates the delivery of personal health care services through state alliances with

the delivery of public health services in order to reach the common goal of improving the health of the American population.

Nursing endorses the Administration's proposal to repair, strengthen and consolidate essential Federal, state, and local public health services. The plan's focus would help to restore the original mission of public health programs to engage in community prevention rather than direct delivery of health services. The plan would support such core public health activities as data collection; surveillance and monitoring; protection of the environment, housing, food, and water; and disease investigation and control.

We applaud the inclusion of a strong public information and education component to mobilize communities and motivate individuals to reduce risks to health. Nursing stands ready to lead community and individual efforts to reduce some of our deadliest and costliest health risks—tobacco use, drug and alcohol abuse, sexual activity that increases the prevalence of HIV infection and other sexually transmitted diseases, inadequate or poor nutrition, physical inactivity, and the lack of childhood immunizations.

REMOVING BARRIERS TO PRACTICE

One of the key features of the Administration's proposal is the elimination of anti-competitive practices in the health care industry would be to ensure that health providers are treated equitably within the health system by removing barriers to practice. In discussing how this can best be achieved, nursing has stressed aggressive enforcement of anti-trust guidelines and a reiteration of their commitment to encouraging competition in the health care marketplace.

Nursing encourages this Committee to develop a new health system that will compel all business entities to treat all health providers in accordance with the legal scope of their practice and will review all actions taken by corporations working within a health plan, especially when they adversely impact upon one class of health professionals.

ADMINISTRATIVE SIMPLIFICATION AND COST SAVINGS

Nurses throughout the nation breathed a collective sigh of relief when the President outlined the need to simplify the mounting paperwork 'and other administrative requirements that burden our health care system. We know firsthand what a waste of professional time these requirements can represent. Too often, nurses are forced to take time away from patient care and devote it to filling out forms. It has been estimated that a staff nurse fills out an average of 19 forms per patient. Thus, we applaud the President's proposals to pare down and simplify paperwork and other wasteful administrative requirements.

However, we need to draw a distinction here between completion of insurance forms and other activities that serve little other than facilitating the flow of paperwork and bureaucracy, and efforts that do facilitate maintaining and improving quality and patient care standards. The Administration's proposal would emphasize data collection that is related to quality of care, development of outcomes criteria and other activities that are directly relevant to patient care. As health care professionals, we regard this as important and necessary. The distinction we make is between needless and endless paperwork and the collection of patient care information that leads to continuous improvement in the quality of care. We are more than happy to give up the former and opt for the latter.

Nursing also supports the greater use of community rating, eliminating pre-existing conditions as a way for insurance companies to reject higher-risk individuals and limiting an individual's out-of-pocket expenses following a catastrophic health event.

CONCLUSION

Mr. Chairman, we commend the Committee for holding this hearing and for working so diligently to find solutions to the health care crisis. We appreciate this opportunity to share our views with you and look forward to continuing to work 'with you as comprehensive health care reform legislation is developed.

Thank you.

The CHAIRMAN. Dr. Lawrence.

Dr. LAWRENCE. Mr. Chairman, members of the committee, good morning—well, I guess it is morning in Texas; it is afternoon here.

My name is Leonard Lawrence. I am a 1962 graduate of Indiana University School of Medicine. I am a child psychiatrist by training

and a community advocate by choice. I have been a faculty member of the medical school of the University of Texas Health Science Center at San Antonio since 1972, and I am currently associate dean of student affairs and professor of psychiatry, pediatrics, and family practice at that institution.

I am here today in my role as president of the National Medical Association, the organization which represents the interests of this Nation's 17,000-plus African American physicians. Since 1895, NMA has been an active advocate for the health care needs of African Americans and for other underserved populations.

I am also here as an interested parent, with three children, two of whom are physicians. My daughter has recently completed a residency in general pediatrics, and my older son is a third-year resident also in general pediatrics. They will be prime movers in the delivery of health care services to minority populations for perhaps the next 30 years.

The National Medical Association applauds the presidential leadership which has led to the current national discussion over health care reform. Our patients within the African American population have long been underserved. Whereas other populations have experienced an increase in life-expectancy during the past 2 decades, the African American population is reported to be experiencing a decrease in life-expectancy. Our excess death rate is significant, and without modifications in the existing process, the outlook will remain bleak.

Minority providers labor under onerous burdens, not the least of which are diminished support for the medical infrastructure within minority communities and limited access to health care training opportunities for minority students.

It is in the context of the above reality that NMA has reviewed the President's health care reform proposals. There are several areas of strength, from our perspective. One, that there is clear, well-defined presidential leadership is a critical issue for the National Medical Association and for a coalition of over 100 other African American health care, civic and social service organizations which have been reviewing issues related to health care needs within the minority communities for the past year.

Two, that a comprehensive basic benefits package which stresses primary care as well as some preventive services is included is also a clear strength.

Three, that pre-existing conditions will not be barriers to coverage is an asset.

Four, that coverage would be portable, that people can move from place to place and still be assured of health care, is seen by the National Medical Association as a clear strength.

Five, that patients and/or consumers would have a choice of plans and providers, including fee-for-service, is clearly a strength.

Six, that recommendations for simplification of administrative process, as illustrated by a standard claim form, is seen as a positive feature by our organization.

Seven, that there is consideration for insurance to be tax-deductible for self-employed persons will especially impact favorably on minority small business personnel.

That attention will be paid to issues of both malpractice and tort reform will be of assistance to minority populations.

Our concerns are in the following areas. One, reform processes should speak directly to the specific health care crisis which exists within the African American community. To date, public discussion of this issue has been limited.

Two, systems must be structured in such a manner as to ensure minority participation at all levels of policy development, process implementation, and decisionmaking. This encompasses both minority providers and consumers.

Three, the National Medical Association supports the full inclusion of Medicaid recipients into a reformed health care system.

Four, the National Medical Association recognizes that the proposal acknowledges the need for an increased number of African American physicians and other providers. We await further delineation and clarification of the mechanisms which will be developed to approach this goal and to respond to the current barriers within and without academic institutions which have impeded minority student matriculation. As one who has functioned in medical education for 21 years, I can speak specifically to the problems that are inherent there.

Five, health care services are best delivered when done so in a culturally sensitive, culturally appropriate manner. Cultural sensitivity involves not only attitudes, but also familiarity in access. The National Medical Association therefore supports front-line providers in all medical settings to include clinics, public hospitals, and other front-line facilities, and clearly expanded funding is required if they are to continue their work.

The managed competition approach has the potential of marginalizing African American physicians and other minority health providers. In a competitive environment, large, well-financed health care organizations with low bottom-line costs have distinct advantages. Regional health alliances will be required to select health plans principally based on cost, as we understand it, not based on quality or cultural sensitivity.

Managed care agencies owned by African Americans, already few and dwindling, face stiff competition in the current competitive environment. It is hard to imagine how these agencies, to say nothing of independent African American physicians, could successfully compete for patients with large megasystems.

It is recommended that patients will be able to choose their providers, but they will have choices among a limited number of approved plans, which may not include African Americans, either as entrepreneurs or as providers. If we are excluded from these opportunities now—and we are at present—the future, under full-fledged managed competition, is clearly of significant concern.

The NMA expects to advance alternative proposals that will hopefully level the playing field and allow our physicians and our consumers to compete as groups and as individuals.

Institutional racism remains alive and well in the health care industry. Health maintenance organizations have taken our patients gladly, but have excluded our physicians with impunity. Redlining is a reality. Racism has been masked by cost-effective decisions, but the results are the same. African Americans are disproportion-

ately served in many HMOs, but clearly disproportionately left out as decisionmakers, managers, and providers. The National Medical Association will be advancing proposals to combat racism within a reformed health care system.

Finally, while State flexibility brings Government closer to the people, it also holds the potential for negative impact on African American citizens. It is much more difficult for us to monitor health care reform in 50 States and to work to prevent abuses. Therefore, we propose that specific national standards be developed and enforced within every State, which assures minority participation throughout the entire system of whatever reformed system is coming.

The National Medical Association is pleased with the opportunity to participate in this debate. We supported Medicare in 1968. We support the concept of health care reform in 1993, and we look forward to continued interaction in service to the people of this Nation, to include minority, underserved, and disadvantaged populations.

Thank you.

The CHAIRMAN. Thank you very much, Dr. Lawrence.

Dr. Graham.

Dr. GRAHAM. Mr. Chairman, members of the committee, thank you very much for the opportunity to be present with you this morning. I am Dr. Robert Graham, the executive vice president of the American Academy of Family Physicians, which has 75,000 members across the country providing front-line primary care, day in and day out, the largest such specialty organization in the Nation.

I would like to summarize briefly for you my statement, which is before you, for the record, pointing out those areas of President Clinton's plan where we are enthusiastic and supportive, and areas where we have questions. Before I do so, I would like to acknowledge that this committee, the chairman in particular, those of you here now and those in the past, have kept the flame alive for the issue of universal enfranchisement over many, many difficult years, and it is a real pleasure to appear before you this morning to finally be able to start to grapple with this issue with some sense that we may actually be able to resolve it in the interest of the public.

The question that everyone has of any medical or provider organization is, What do you think about the President's plan? We think the President has made an important and historic first step. It is in many ways very consistent with the principles for universal enfranchisement that the Academy has been advocating for 5 years. If we had imagined when we began in 1989 with our advocacy of this issue that we would have a President within 4 to 5 years who would deliver a plan to Congress so consistent with the principles that we had articulated, we would have been ecstatic.

Most important to us in those principles is the fact that there will be universal enfranchisement; every American will have access to a defined, comprehensive set of benefits. Second, those benefits will be comprehensive. We will have individuals receiving the care they need—preventive, health maintenance, curative, catastrophic. Third, there will be pluralism in the system. We will be able to do

this not out of Baltimore, not out of HCFA, but State by State, city by city. Individuals as patients will have a choice of providers, will have a choice of plans. Individuals as physicians and nurses will have a choice of how they practice their respective professions.

Last, there is a serious recognition of the need for cost containment. We do not believe that it is possible to reform and reshape the health care system in the United States unless there is a commitment to containing the increasing rise in cost that the total system takes out of our economy. Since Medicare passed, the percentage of gross domestic product in 30 years has doubled, from 7 to 16 percent. It cannot double in another 30 years. We must deal with cost containment.

As previous speakers have indicated, no plan is perfect. We do have areas of continuing concern. We acknowledge that the President and his staff are continuing to work on revision of the proposal we saw in early September. There are areas where we are in discussion with them, areas that we think are perfectible and changeable. We do not believe that the President's proposal at the present time goes far enough in providing regulatory relief to providers in areas ranging as broadly as antitrust protection, so that providers can organize and participate fully in this reform system to areas as nitty-gritty and day to day as the Clinical Lab Improvement Act, which is a tremendous burden on the practicing primary care physician. We need more regulatory reform and relief.

As Dr. Todd has indicated, we are very disappointed that they have not gone further in terms of tort reform. If it is legitimate and reasonable to think about global budgets for the health care system, it is legitimate to think about some sort of global controls on our spiralling malpractice costs.

We believe that there are open questions in terms of the way the system will be financed and the way the cost containment mechanisms specified will actually operate. We are not convinced that adequate assurance and provision has been made to assure that every American does have access to a personal physician who can provide the majority of their medical care on a first contact basis, when they need it and where they need it. And we are also not convinced that there has been adequate attention paid to the implications of personal behavior and choice in health status and health outcomes.

I believe that we are beginning on a historic conversation and journey. We have heard some reference that the system is not sustainable. Not only is the system as we see it today not sustainable; it is inequitable. We do need to change it. It has needed attention for 10 to 20 years. This President for the first time in 40 years will send a comprehensive health reform bill to the Congress. For that, we applaud him and we support him. We have looked forward to the opportunity to now work with the Congress so that a bill can be put together within the next 12 months that is passable by the Congress and signable by the President.

I will close with a comment that the first speaker began with. In politics, timing is everything. Now is the time.

[The prepared statement of Dr. Graham follows:]

PREPARED STATEMENT OF ROBERT GRAHAM

I am Robert Graham, M.D., Executive Vice President of the American Academy of Family Physicians. The Academy is the national medical specialty society representing over 74,000 family physicians, family practice residents and medical students. It is my pleasure to appear before you today to share with you the views of our membership on the critical issue of health system reform.

BACKGROUND

Since the mid-1980s the issue of universal access to care has been a focal issue for the Academy. At that time the impetus for national concern was primarily the growing number of uninsured people and their inability to access appropriate care. Studies documented what family physicians have long known, that people who delay seeking medical care have higher morbidity and mortality and are more costly to treat. As the percentage of the GDP spent on health care in this country has escalated, national attention on the problem of access has shifted to an equivalent concern about cost. The American Academy of Family Physicians shares these dual concerns.

In response to our member's concerns, in 1989 the Academy became the first physician organization to develop a plan for universal access through a public-private effort, building on the current model of employer-based insurance. In April 1992 the Academy released its revised and expanded plan for health reform, Rx For Health: The Family Physicians' Access Plan. Permit me to briefly describe the principal elements of this plan. Rx For Health calls for universal access to a comprehensive set of benefits, emphasizing preventive services. It builds upon the present employer-based system and requires all employers, including small businesses. to provide insurance to their employees and dependent family members. Employers pay a specific portion of the premium. Employee cost sharing is based on income. with subsidies available. A key element of the Academy's plan calls for each person to have a Personal Physician, who is in one of the generalist specialties (family practice physician, general internal medicine or general pediatrics). Increased cost sharing is incurred if an individual chooses to seek non-emergency subspecialty care without a referral from the Personal Physician. Rx For Health includes specific strategies for moving toward a physician supply that is a balance between generalists and specialists. Further, it calls for improved quality utilizing practice parameters and malpractice reforms, including caps on noneconomic damages. And, to address the spiraling health care costs, it includes stringent cost containment provisions, including the establishment of a National Board with authority to set and enforce global spending targets. Enforcement is targeted specifically to those segments of the health care system responsible for inappropriate spending increases.

Rx For Health was and is the Academy's vision of health system reform. It has formed the basis of our discussions with members of the House and Senate and with the Administration. It is the gold standard against which we evaluate proposals for reform, and it includes the specific elements that we will seek as you work for enactment of comprehensive reform.

As we strive for this mutual goal, the Academy believes that we must keep in the forefront of the discussion the original impetus for seeking reform—universal access to a comprehensive benefits package, assurance of high quality care, and control of health care costs. In the following statement, we comment on the Clinton plan and compare its principles with those in Rx For Health. We then highlight those elements of the plan of particular interest to the Academy over which your committee has jurisdiction.

THE CLINTON PLAN

The Academy has had significant interaction with the Administration during the development of the Clinton health plan and is continuing to work with the White House as the final revisions of the plan are being made. We have had the opportunity to review the September 7 draft and have measured it against the principles outline in Rx For Health. The Academy commends the President's leadership and initiative in identifying health system reform as a priority issue and in developing a comprehensive plan. He has demonstrated a willingness to work with consumers. providers. businesses and others organizations invested in health reform and has expressed a commitment to work with the Congress for passage of a comprehensive plan.

Additionally, the work of the Senate Republicans to study the complex issues and develop a legislative proposal is deeply appreciated by the Academy. It is a significant contribution to the debate. We have reviewed this proposal and note that many

of its principles are consistent with those in Rx for Health. The bipartisan effort in Congress to promote positive solutions to problems in our health system is encouraging.

How does the Clinton Plan stack up against principles in Rx for Health?

The following is a comparison of the major principles of Rx for Health and those included in the Clinton plan. In general, the approaches outlined in the plans are very consistent.

Universal health insurance coverage: Rx for Health calls for universal health insurance coverage achieved through employer based plan in combination with state-sponsored public plans that would replace Medicaid and provide coverage for eligible low income individuals and employees of small businesses.

The Clinton plan calls for universal coverage that is employer-based. Medicaid-eligible individuals receive coverage through health alliances, as does the general population. Subsidies are available for those with low incomes. Small businesses pay an amount between 3.5 percent and 7.9 percent of payroll based on the average employee wages. No business will pay more than 7.9 percent of payroll.

Physician specialty distribution: Rx for Health addresses the shortage of generalist physicians, calling for at least 50 percent generalist physicians, at least half of whom are family physicians, through changes in Medicare GME and incentives for ambulatory based training.

The Clinton plan also calls for 50 percent primary care physicians (defined as family medicine, general internal medicine and general pediatrics), but does not specify a percentage of family physicians. It takes an aggressive regulatory approach that includes reform of GME payments.

Basic health benefits: Basic health benefits in the AAFP plan ensure comprehensive coverage, emphasize prevention, and utilize cost sharing to promote cost-effective delivery of care. Rx for Health specifies that self-referral for services not ordered by the personal physician have a higher patient cost-sharing.

The Clinton plan includes a comprehensive benefit package, including preventive services. Provisions for limiting payment for services obtained on self-referral in non-fee-for-service plans are provided. In the mandatory fee-for-service option. the use of a gatekeeper is prohibited.

Cost containment: Cost-containment in Rx for Health includes a national global budget set by a national health commission and enforced, if necessary, by limiting provider payment increases or otherwise controlling expenditures under private and public plans.

The Clinton plan includes a stringent cost containment initiative, but specifies the target rates of increase in the plan itself. It also provides for a National Health Board.

Quality: Rx for Health calls for quality of care to be protected and enhanced through a variety of reforms and research efforts.

The Clinton plan places significant emphasis on quality and replaces the PRO program with a new Quality Management Program.

Insurance reform: Rx for Health calls for insurance reform, including requirements that all health plans be guaranteed issue, guaranteed renewable, and community rated. It ensures the portability of basic health coverage.

The Clinton plan includes all of the above insurance reforms.

Malpractice reform: Rx for Health calls for comprehensive malpractice reform, including limits on payments for non- economic damages, limits on attorney's fees, elimination of joint and several liability, reduction in awards by the amount of compensation from collateral sources, and structured payment schedules to replace lump sum awards.

The Clinton plan includes an alternative dispute resolution mechanism. certification of merit. limits on attorney's fees, collateral source rules, periodic payment of awards, demonstration projects on enterprise liability, and a pilot program using practice guidelines. There is no cap on non-economic damages.

Medicare: Rx for Health calls for Medicare beneficiaries to have coverage comparable to the basic benefit package.

The Clinton plan permits states to integrate Medicare beneficiaries into health alliances if they have the same or better coverage as Medicare. After the health alliances are established, individuals have the right to elect to remain in alliances after age 65 and receive the national guaranteed package.

Financing: Rx for Health finances the plan through a surtax on personal and income tax liabilities, increases in excise [axes on tobacco and alcohol, and taxing as income to employees that portion of employer paid premiums in excess of the premium needed to provide the basic benefit package.

The Clinton plan includes increases in excise taxes and the tax cap, but does not increase income taxes. The plan relies heavily on Medicare savings.

Based on the draft plan and the President's speech to Congress, the Academy applauds the direction and supports the principles and many of the strategies espoused in the Administration's health reform proposal. The draft plan provides a positive framework for considering the many complex issues entailed in health system reform.

From the perspective of this organization, the Clinton plan holds the promise of reforming the health care system in a positive direction. We are particularly pleased with the commitment of the President to universal access to a set of comprehensive benefits that include preventive services and prescription drugs and that provide a good start on mental health coverage. These are services often overlooked in insurance benefits packages. As deliberations on reform continue, these elements must not be compromised. All people in the United States must have access to comprehensive, affordable, high quality health care services.

I will next address a set of health reform issues that the Academy regards as essential and that we believe will receive consideration in your committee deliberations. Our comments focus on efforts to achieve the appropriate supply of primary care physicians, the role of non-physician providers, the need for family practice and primary care research, regulatory burdens, malpractice reform, and fraud and abuse.

ACHIEVING AN APPROPRIATE PHYSICIAN SUPPLY

While much has been said in the past year about the shortage of generalist physicians—family physicians, general internists and general pediatricians—the rhetoric is often unmatched with action.

We are particularly pleased that Clinton the plan focuses attention on and identifies specific strategies for achieving a more appropriate balance of generalist and specialist physicians. Physician workforce goals mist reflect the health care needs of the population. Correcting the problems of specialty imbalance in the system will require significant changes in current federal policies and aggressive interventions. These efforts are controversial as they challenge the status quo, but are essential if we are to achieve universal access to comprehensive health benefits. This will be one of the most difficult and challenging legislative issues. While many offer rhetoric on the need for more generalists, few are willing to take meaningful action. The strong message currently in the plan regarding physician workforce is critically important.

As this committee considers its deliberations on health system reform, we urge you to address the issue of ensuring a physician supply that is adequate and appropriate to meet the health needs of the population. While grappling with strategies for meeting the demand for primary care service, however, we urge that primary care not be trivialized in the process.

A primary care physician (or generalist physician) provides definitive care to the unselected patient at the point of first contact. Such a physician will have been specifically trained to provide primary care services, usually through completion of a residency in family practice, general internal medicine or general pediatrics.

Primary care physicians devote the substantial majority of their practice to providing primary care services to a deemed population of patients. The style of primary care practice is such that the personal primary care physician serves as the first point of contact for substantially all of the patient's medical and health care needs.

Occasionally, individuals who are not trained as primary care physicians will provide patient care services within the domain of primary care. These limited primary care providers may be physicians from other specialties. nurse practitioners. or physician assistants. Such providers may focus on patient care needs related to prevention, health maintenance, acute care, chronic care or rehabilitation.

The contribution of limited primary care providers may be important to specific patients. However, the absence of a full scope of training in primary care and limited practice skills in providing full primary care services requires that such providers work in close consultation with fully trained primary care physicians. Effective systems of primary care will use limited primary care providers as adjuncts to the health care team with primary care physicians taking responsibility for the total care of each patient.

We understand that obstetricians-gynecologists have sought to be recognized as primary care physicians. The fact that Ob-gyns provide certain services that are within the domain of primary care is well recognized. Furthermore, we recognize that many women receive the majority of their health care from Ob-gyns during cer-

tain periods of their lives. However, the commonly accepted definition of primary care incorporates a much broader range of skills and knowledge than is present in Ob-gyns. As deemed by the Council on Graduate Medical Education, primary care entails first-contact care of persons with undifferentiated illnesses, comprehensive care that is not disease or organ specific. care that is longitudinal in nature, and care that includes the coordination of other health services. In its fullest sense, primary care includes the assessment and evaluation of signs and symptoms initially presented by the patient, the management of acute and chronic medical conditions, the identification and appropriate referral of conditions requiring specialized care, and the provision of health promotion and disease prevention services. While a number of providers receive training in and typically provide some important aspects of primary care, it is only the primary care specialties of family practice, general pediatrics, and general internal medicine that are specifically and fully trained to provide the broad range of primary care competencies. We note that the Ob-gyn literature clearly acknowledges the limited role of Ob-gyn in the provision of primary care.

As the definition of primary care is used in the President's health reform plan, it dictates a substantial redirection of training funds. Because the role of Ob-gyn in primary care is limited. we are very concerned that efforts to improve access to primary care will be compromised by including Ob-gyn in the definition of primary care. Increasing the training funds for Ob-gyns will not substantially improve the number of providers of primary care services. Furthermore, including Ob-gyns in the definition of primary care suggests that there are available many more primary care physicians than is, in fact, the case.

We understand that many women may, by personal preference, choose to obtain the majority of their routine health care from an obstetrician-gynecologist during certain periods of their lives. We support the continued opportunity for women to make that choice. This is clearly an option that will be preserved under the mandatory fee-for-service plans, and we expect that many managed care entities will allow women to utilize an Ob-gyn routinely. What is at issue for the Academy is improving access to primary care services. An important part of addressing this issue is training more primary care physicians. We believe this best accomplished by leaving undiluted the current definition of primary care (family medicine, general internal medicine, and general pediatrics). Prior to reaching a final decision on this issue we would urge you to pose the following questions to the Ob-gyn community:

- What percentage of currently practicing Ob-gyns spend the majority of their clinical practice providing services in the domain of primary care?
- If all Ob-gyns are classified as "primary care providers." how will the Ob-gyn community assure women that a specific Ob-gyn physician is both willing and competent to serve as her primary care physician?
- If Ob-gyn, as a specialty, is classified as "primary care," in what ways and how rapidly will Ob-gyn residencies redirect their current training towards the full competencies of primary care providers?

Unless you are satisfied by the answers to these questions that Ob-gyn will truly function as a primary care specialty in the future, we would urge you not to change their specialty designation in the President's plan.

NON-PHYSICIAN PROVIDERS

As the challenge of moving toward an appropriate balance of generalist and specialists in the physician supply is addressed, the related issue of the role of non-physician providers in the health care system emerges.

At a recent meeting with the Academy, Administration officials indicated that the language in the September 7 draft dealing with barriers to the practice of nurse practitioners, nurse midwives, and physician assistants (hereafter referred to as non-physician providers) would possibly be strengthened to include a pre-emption of state laws and regulations deemed to be overly restrictive. We believe that the language contained in the September 7 draft provides sufficient means to address unwarranted barriers to the practice of non-physician providers and, furthermore, the current language avoids unnecessary consequences that would accompany a federal pre-emption. Preempting state practice acts would constitute an unwarranted federal intrusion in an area of traditional state jurisdiction and may result in adverse consequences for both the cost and quality of care.

As the plan currently reads, the Secretary of the Department of Health and Human Services is directed to develop and encourage the adoption of model professional practice statutes for advanced practice nurses and physician assistants (page 130). In addition, an earlier section defining a covered service establishes a standard

that prevents any state from limiting the practice of any class of health professionals except as justified by skill and training (page 21).

No topic that we will address in this letter presents more difficulty to a physician. We recognize that it is all too easy to read into these words an attempt to simply protect professional "turf." Allow us. therefore, to preface these comments by noting that no other physician specialty is as likely to be engaged in collaborative practice with non-physician providers. We fully appreciate the substantial contribution of non-physician providers to the delivery of primary care. Furthermore, our members are cognizant of the fact that many state laws impose undue restriction on the practice of non-physician providers. We approach this issue supporting the expanded utilization of non-physician providers and the elimination of undue barriers to their practice.

The substantial abilities of nurses to provide certain high quality services that are within the domain of primary care is well recognized. However. the commonly accepted definition of primary care incorporates a much broader range of skills and knowledge than is present in any of the non-physician practitioners. While a number of providers receive training in and typically provide some important aspects of primary care, it is only the primary care specialties of family practice. general pediatrics, and general internal medicine that are specifically and fully trained to provide the board range of primary care competencies. (See also our comments above on obstetrics and gynecology as "primary care physicians.")

We find the call for the unsupervised practice of primary care by non-physician providers unsupported for a number of reasons. First, while generally positive in its findings, the available research on the quality of care and cost-effectiveness of non-physician providers is limited in the scope of services examined, employs a narrow-range of quality measures, and provides no basis on which to judge the quality and cost-effectiveness of unsupervised practice. All of the studies of which we are aware examined non-physician providers practicing with physician supervision. The claim that unsupervised non-physician practitioners can provide the full range of primary care services with physician-like quality has absolutely no basis in research.

Second, we note that the call for independent non-physician provider practice comes from a relatively narrow segment of the non-physician provider community. The physician assistant profession has explicitly rejected independent practice. The non-physician providers with whom family physicians work, especially those who practice in remote settings without on-site supervision, do not consider independent practice to be professionally responsible. They, as well as their patients, need to know that when confronted with a serious or confusing medical condition, a responsible supervising physician is immediately available to provide either consultation or direct intervention. Anything less risks compromise in the quality of care.

If, however, for whatever reason you decide to propose a federal pre-emption of state medical practice acts in order to remove barriers to the practice of non-physician providers, we believe that the same logic and mechanism should be applied to state nursing acts. As you may know, many hospitals have sought to improve efficiency and productivity by utilizing non-RN personnel to provide numerous patient care tasks. These efforts have been frustrated by the nursing profession, which has asserted that an RN's license is required to provide many routine bedside duties. To address only one aspect of this issue of "barriers to practice" in the President's proposal would be intellectually inconsistent.

REGULATORY BURDENS

The Clinical Laboratory Improvement Amendments (CLIA) regulations are perhaps the most onerous federal requirements presently imposed on family physicians. The level of regulation, expense and exasperation inflicted on small physician office laboratories has no relationship whatever to improvements in patient care or patient safety. The impetus for CLIA '88 was a response to quality problems in large reference laboratories performing Pap tests, not physician office laboratories. However, the resulting law subjects office laboratories to the same level of regulation as reference labs. This makes no sense in terms of quality of patient care, and, in fact, has resulted in reduced access to testing and increased expenses for physicians. As you work to reform the health care system and develop regulatory strategies that improve efficacy and cost-effectiveness, the Academy again urges you to call for repeal of CLIA provisions relating to physician office laboratories and instead concentrate efforts on improving quality of Pap testing.

While the Academy appreciates the initial efforts outlined in the plan to provide a measure of relief from the regulatory burden, practicing family physicians who have reviewed the material are concerned about the stipulations that regulation will continue for labs that engage in critical testing or conduct testing to monitor care

while it is being delivered. These provisions will largely undermine the efforts in subsequent sections aimed at easing the regulatory burden on labs performing simple and moderately complex tests. As an inherent component of patient care, family physicians routinely perform lab tests to get immediate results in order to begin appropriate treatment and monitor care while it is being delivered, not dissimilar to physicians who perform microscopic tests. The choice, timing, and interpretation of laboratory tests are integral to a physician's clinical decisions regarding subsequent diagnostic and treatment interventions. Lab procedures are not a separable aspect of clinical medicine. To continue the present regulations in these instances will continue the present unreasonable regulatory burden.

We urge deletion of the requirement for continued regulation of labs engaging in critical testing (a test is critical if an answer is needed quickly or an error can result in serious harm to an individual) or conducting testing to monitor care while it is being delivered.

Other federal regulations also serve only to increase the cost of medical care and the administrative burden on physicians without any measurable benefit to patients. The present OSHA bloodborne pathogens regulations are a good example. The Centers for Disease Control guidelines for universal precautions are straightforward and afford patent and health professional safety in regard to HIV infection. Hepatitis B, and other diseases. The OSHA regulations, enforced by intimidating OSHA inspectors, are excessive and threatening to physicians. We urge that you call for repeal of this overly burdensome regulation and, instead, acknowledge the appropriateness of the CDC guidelines.

HEALTH RESEARCH INITIATIVES

The health research initiative described in the September 7 draft limits new funding for health research to two areas, prevention research and health services research. While these are important, the draft plan omits a highly relevant and to-date largely ignored research area, family practice and primary care research. For the past 30 years, over 95 percent of all medical conditions have been evaluated and treated outside of hospitals. However, the traditional focus of medical education and research has been on medical problems in referred and hospitalized patients. Thus. the training of physicians and the research agenda have focused almost exclusively on inpatient rather than outpatient evaluation and treatment.

Given that the National Institutes of Health has not in the past and does not now include primary care research, and given that the limited resources and other priorities of the Agency for Health Care Policy and Research have precluded all but the most limited attention to it, we believe that it is imperative to identify family practice and primary care research as a priority in health system reform.

The draft plan placed considerable attention on effective strategies to emphasize [inning of generalist physicians in ambulatory settings to meet the considerable demand for primary care services. However, the research initiatives portion of the plan is deficient in the comparable area of research. We therefore suggest that a third focus for new funding for health research be specified as family practice and primary care research.

Suggested language follows:

> Family practice and primary care research related to better assisting the generalist physician in diagnosis and treatment of the undifferentiated patient population treated in the ambulatory care setting.

PRIORITY AREAS FOR FAMILY PRACTICE AND PRIMARY CARE RESEARCH

The Agency for Health Care Policy and Research and/or the National Institutes of Health initiates and expands office-based, community-oriented family practice and primary care research in priority areas including:

> Research to better understand the role of diagnosis in family practice and primary care to assist the generalist physician to evaluate the myriad symptoms of the patient, differentiate self-limited diseases from those requiring ongoing or intensive treatment and initiate effective treatment. The tangible benefits of such research could streamline the diagnostic process, increase accuracy, and reduce the use of expensive and potentially dangerous medical tests.
>
> Research to improve the effectiveness of medical care as the physician, in collaboration with the patient designs and implements an effective treatment that reconciles the idiosyncrasies, preferences and the needs of the patient with the realities of the illness.
>
> Research to improve access to health care and the cost-effectiveness of care focusing on the role of frontline, generalist physicians.

We appreciated the attention that this committee gave to primary care research in report language accompanying last year's reauthorization of the Agency for Health Care Policy and Research. We look forward to working with you to improve the federal effort in this important research arena.

MALPRACTICE REFORM

While provisions of the draft plan to address malpractice concerns are consistent with those supported by the Academy, it is silent on two effective strategies that have been utilized in state malpractice reforms: the limit of payments for non-economic damages and a statute of limitations for filing a claim. Additionally, two provisions need to be strengthened. First, the requirement for a Certificate of Merit does not specify that the physician submitting the affidavit be of the same medical specialty and be actually practicing in the field of the defendant physician. We believe this is essential to provide an accurate assessment of whether the physician deviated from the established standard of care. Second, in its present form, the alternative dispute resolution mechanism would add more administrative burden to the resolution of malpractice claims than it would eliminate.

We suggest the following language (both modifications and additions) to the proposals relating to malpractice reform in the draft:

Creation of Alternative Dispute Resolution Mechanisms (modification underlined). Each health plan establishes an alternative-dispute resolution process using one or more of several models developed by the National Health Board. Potential model systems include early offers of settlement, mediation and arbitration.

Consumers who have a claim against a health-care provider are required to submit the claim through the alternative dispute system. At the completion of the alternative dispute system, if one of the parties in the dispute wishes to challenge the outcome of the alternative dispute resolution, he or she may do so in court. If the decision rendered in court is less favorable to him or her than in the alternative dispute resolution, he or she shall pay all legal fees.

Requirement for Certificate of Merit (modification underlined). Lawsuits claiming injury from medical malpractice include submission of an affidavit signed by a physician of the same medical specialty and practicing in the same medical specialty as the defendant physician. The affidavit must attest that the specialist examined the claim and concluded that medical procedures or treatments that Produced the claim deviated from established standards of care.

Statute of limitations (additional section). A claim must be filed within 2 years from the date that the alleged injury should have reasonably been discovered, but in no event more than 4 years from the time of alleged injury. In the case of alleged injury to children under 6, a claim must be filed within 4 years from the date that the alleged injury should have reasonably been discovered.

Limits on non-economic damages (additional section). The plan establishes a $250,000 limit on non-economic damages, often referred to as "pain and suffering" awards.

FRAUD AND ABUSE

While the Academy supports the effort to eliminate provider initiated fraud and abuse, certain provisions place providers at undue risk, particularly in regard to false claims for deliberate upcoding (p. 174). However, there is currently considerable disagreement about the utilization of the various levels of visit codes between physicians and Medicare carriers. Physicians who have performed the services described in the CPT coding manual for a particular level of visit are challenged by carriers and accused of "upcoding." As we interpret this section, these physicians, who believe they have submitted codes that are consistent with the services provided, would be subject to assessment of civil monetary penalties.

Another concern relates to preventive services. Physicians have neither coded nor charged for preventive services, because these services currently are not covered. Physicians expect to appropriately code and charge for these services when included in the nationally guaranteed benefits package. We are concerned that physicians charging for previously uncovered services may be subject to charges of "unbundling" and the commensurate civil monetary penalties.

While deliberate upcoding and unbundling should be prohibited. we believe that including these as false claims and subjecting them to severe penalties should be reconsidered in light of current problems with the use of visit codes and potential accusations of unbundling when appropriately coding for newly covered services.

We are also concerned about the provision to toughen penalties for wrongdoers that allow forfeitures of proceeds derived from health care fraud. In view of the

above definitions and identified implementation problems, the penalties appear too stringent.

Physicians who now live in fear of inadvertently committing Medicare fraud and abuse will have this fear considerably increased by the proposed provisions.

CONCLUSION

The time has come for comprehensive health system reform. This will be challenging for the Congress. the Administration, health care providers, businesses, and patients. Change, even positive change, is always difficult. However, the status quo no longer is acceptable. The American Academy of Family Physicians looks forward to working with you to achieve the positive change that we all seek.

I thank you for the opportunity to appear before you and would be pleased to answer any questions.

The CHAIRMAN. Thank you very much.

We have six members here, and we will follow a 5-minute time limit and try to wind up as close to 1 o'clock as we can. I know there are party meetings, so we will proceed that way, and if we get through earlier, we will continue with an additional round.

I would like to begin with a threshold question for Dr. Todd. Dr. Todd, you have expressed a number of concerns about the President's plan. Do you think these concerns will prevent you from working constructively with the President and the Congress to pass the kind of comprehensive reform that can meet the needs of the American people?

Dr. TODD. Absolutely not. The need for reform is now. The President has provided a good foundation from which to start. We have found him to be responsive to some of the concerns that we have raised, and we need to go forward with the President, with this committee, and with the Congress, and get it done.

The CHAIRMAN. Let me ask you again about the areas of agreement and disagreement, Dr. Todd, and then I would ask the other panelists this question. You agree on universal coverage; that an employer makes a contribution and individuals make a contribution; assistance for low-income individuals, and a national benefit package.

Are you all in agreement on that?

Dr. TODD. Yes, we are.

The CHAIRMAN. Let the record show that there is agreement on those issues.

Then, there is the fee-for-service option; the emphasis on individual choice; insurance reform should include no pre-existing exclusions, and should have open enrollment. Is there agreement on all of those?

Dr. TODD. Yes, there is.

The CHAIRMAN. All right. Malpractice reform, and a commission or a board—I think there were references in all of the testimonies to either a commission or a board. There are differences as to what the function ought to be with regard to the commission or board, but nonetheless, as I understand, there is agreement that that kind of formulation makes sense.

Dr. TODD. That is correct.

The CHAIRMAN. Is there agreement on global budget, but that the budget and fees are negotiated with the providers?

Dr. TODD. We do have a problem with the global budget, but I think you have expressed it very well, that if the profession and all of the providers are involved in looking at what patients need

and how best to supply that need, it becomes clear there has to be a degree of economic discipline introduced into the system.

We would prefer to do it based on patient need, efficiency, and effectiveness rather than on choosing some arbitrary number that may or may not serve the patients of this country well. But given the ability to sit down and negotiate budget predictability, we would be in agreement.

Dr. GRAHAM. We have felt for a number of years that the only way to get reform is to have economic discipline. Our plan itself calls for an approach to global budgeting. We do not differ substantially with what Dr. Todd has said, but the bottom line is without that discipline, there will be no lasting reform.

Dr. LAWRENCE. And our position is that it must be recognized that when we talk about patients' needs, patients' needs vary across groups. Within our community, the patients' needs are so severe that we do not want to be locked out by any limitation which would restrict resources that could become available to the sickest segment of our population.

Ms. SHINN. And I would say, Senator, that we believe that greater utilization of registered nurses in our system is going to help a lot with our economic discipline.

The CHAIRMAN. OK. I just have time for one more question, and it is targeted at Dr. Lawrence, but others may wish to make a brief comment. How concerned are you as these budget crunches are put in place, so to speak, in terms of whatever is worked out in terms of the cost restrictions, that it is going to mean a diminution of care for the needy and the poor in our society?

Dr. LAWRENCE. Let me say up front, I am not a financial expert. I am a hard-working, day to day doctor. However, I have opinions. The populations whom my organization serves are those who, again, are most in need of resources, and those whose needs historically have been cut first when there were budget crunches. It may not appear that way to a lot of people on the outside, but the impact of budget cuts across-the-board within minority communities is devastating because of the total dearth of resources that are there now.

Anything that seeks to limit the economic development, the resource allocation within communities which are at greatest need, my organization does have a problem with.

The CHAIRMAN. Thank you.

Senator Jeffords.

Senator JEFFORDS. Let me follow up on that because it does concern me. In other words, the system which is outlined in the Clinton plan which would require physicians to receive lower payment for services to subsidized poor if you are in an area that has large numbers of subsidized poor, and you try to average that into the premium, it is going to be extremely difficult to do,is it not?

Dr. LAWRENCE. Senator, with all due respect, I do not have the knowledge that allows me to go through the mathematic manipulation, but let me say it like this. Physicians in inner cities and underserved areas already are, relatively speaking, undercompensated. Primary care physicians are clearly under compensated. If there is a restriction on their ability to be able to appropriately meet even their own expenses as other costs increase,

then we further contribute to a diminution of health care—quality health care—within undeserved and minority communities.

Again, I think this needs to be part of the general consideration as we go through this process, because I realize we are not at a final end point right now.

Senator JEFFORDS. If the other doctors would comment on that part of the plan, which I believe would require you to receive a lower fee for service to subsidize patients.

Dr. GRAHAM. Let me start at the other part of the plan. Yes, that provision does have application, but the intent of the plan is to require the accountable health plans to have available services throughout any area where they wish to market and to provide the patient with the total option, on a year by year decision, on as to which plan they seek their care from.

It would be my anticipation that if that worked in the manner described, what you are going to have is a reversal of the concentration that we now find of disadvantaged populations within an area as they can seek care in the direction that they wish, and on top of that, there are specific provisions for the public health infrastructure.

So yes, that provision is there. As our members have looked at it, they see 30 percent of the patients every day, and those are patients by and large that they are not getting paid anything for.

Dr. TODD. Really, Senator, from our point of view, the question is equity, fairness for all, to take care of those who need to be cared for in a setting where they can choose what best suits their needs, and that the resources be made available to take care of those who have thus far been shut out of the network. And Dr. Graham makes a very good point—when we have universal coverage, care that is now going uncompensated and therefore contributes to the cost shift, that cost-shifting may well diminish and allow those who cannot now afford to get into the system to access it more easily.

Senator JEFFORDS. What protection will doctors need against being excluded from being able to participate in a health alliance? Dr. Lawrence talked about minorities, but I know in my State already, one was formed leaving one doctor out. How are you going to cope with that, or should it be coped with?

Dr. TODD. Senator, that is a tough issue. We are talking about competition. Competition means winners and losers, and obviously, nobody likes to be a loser. From the AMA's point of view, our position is that decisions regarding allowing physicians to participate in these health care alliances and plans depends upon their training, their demonstrated experience, and their willingness to conform to the requirements of the plan.

We also believe this is part of the reason why physicians do need the ability to come together and be able to negotiate with some plans that may, for reasons that are not totally appropriate, tend to exclude physicians who should be allowed in the plan because of the mix of demography, the need for specialists, and other reasons we can talk about.

Negotiation for physicians becomes very important in trying to continue to act as advocates for patients to make sure that the plans are fair and their coverage is fair and their treatment is fair and their prices are fair.

Dr. GRAHAM. That is one of the reasons I emphasized our disappointment with the extent of antitrust relief. We anticipate that for many family physicians, where they participate in one or more plans, much less being excluded, they will want to look at the option of organizing themselves as a primary care group, region by region and State by State.

Senator JEFFORDS. Dr. Lawrence.

Dr. LAWRENCE. Well, it is one of the reasons why we want to see very clear monitoring of the kinds of criteria that are going to be set up for inclusion. Granted, physicians may be excluded from interaction for a variety of reasons, many of which may come out under the rubric of board certification, under the rubric of qualifications. On the other hand, we think that new parameters of standards of practice may need to be developed within certain interactions, within certain organizations, so that minority physicians just because of the training that they, quote, "did not have," or the board certification that they did not have, are automatically excluded from participation in areas where they were previously delivering service, but now that the patients can be paid for, other external groups want to come in and take over those systems.

Senator JEFFORDS. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Metzenbaum.

Senator METZENBAUM. Dr. Todd and Dr. Graham, you both have talked about exemptions from our Nation's fair competition laws, the antitrust laws. You even suggest that the AMA should get some kind of special exemption that would permit them to negotiate fees on behalf of unrelated groups of doctors.

Now, I am frank to say to you that I am a little disappointed we have not heard from the AMA, nor from your group, Dr. Graham. We have heard from the Hospital Association, and we have been successful in working out solutions to any concerns.

The fact is the antitrust laws do not prevent groups of doctors from negotiating fees with health alliances or any large insurer. The recently published antitrust guidelines make that very, very clear. The only requirement under antitrust laws is that doctors form themselves into some kind of group practice, a PPO or an independent practice association, when they negotiate fees. In other words, doctors must have some real incentive to bargain more like a cost-efficient single entity than a group of price-fixing competitors.

Wouldn't you both agree that your proposal could actually increase the cost of health care for most patients and undermine health care reform because it would discourage doctors from joining cost-cutting group practices?

Dr. TODD. I think I would have to answer that in the negative, Senator Metzenbaum, and in all honesty, we have been making contacts with your office; we have been in to the Justice Department, we have met with Mrs. Bingaman, who is the deputy attorney general in this respect. And our interest is not in any special exemption for the AMA or for any group of physicians that is not in the best interest of health system reform.

You heard Senator Wellstone talk about the mega companies that are going to be coming along, and in some of the rural areas

of this country, it is impractical for physicians to be able to integrate their practices in the fashion that the current antitrust statutes require. Therefore, if they are going to be able to negotiate on behalf of their patients, if they are going to be able to negotiate on the conditions of participation, they must be able to come together as independent practitioners. Obviously, they are not going to strike; obviously, they are not going to boycott. But they certainly ought to have the ability to express their opinions both as to conditions of participation and reimbursement.

If indeed we are going to have the concentration of purchasing power in the hands of mega organizations, what is it that physicians can do to protect their patients and protect their ability to provide necessary care?

Senator METZENBAUM. They could have a PPO or an independent practice association. They can do that. There is no problem with that under our antitrust laws.

Dr. GRAHAM. If I could respond to that, because you cited our specific example, family physicians, if they organize for the purpose of negotiation with the alliances as they appear right now, probably wouldn't organize into a PPO or an IPA as you recognize them. They are primary care physicians. They are not a vertically oriented, multispecialty group. That is one of the difficulties that we have in looking at new models and the flexibility of negotiation.

And I must say as that as I travel throughout the country and meet with our members, the advice that they are getting from counsel, State by State, is to stay away from it. The climate of intimidation and risk aversion that has been generated by the Justice Department's efforts in antitrust in the professional area is such that it makes a country doctor very, very reluctant to talk about it when their lawyer is sitting right beside him, saying, "Stay away, doctor."

Senator METZENBAUM. You know, Dr. Graham, I sat before a committee of five United States Senators not too long ago, chaired by Senator Rockefeller, including Senator Baucus, Senator Durenberger, Senator Chafee, Senator Daschle, and they were all concerned about the hospitals and the question of what happens to the rural hospitals. That was the bugaboo. And I said then that these matters can be worked out and that they do not need to change the antitrust laws. And in fact, we have now worked them out.

I would say to you that I think these matters can be worked out so that the rural physician and the city physician can get their fair share, they will be able to negotiate on a fair basis. But I think the idea of a new antitrust exemption is most distasteful to many of us, and I think we are prepared to try to be helpful to deal with the real problems.

If I have time, Mr. Chairman, I have one more question on another subject.

The CHAIRMAN. Go right ahead.

Senator METZENBAUM. Let me just address myself to this matter of malpractice coverage and insurance, that big bugaboo that is going to give all these plaintiffs' lawyers millions of dollars, and indeed that has been the case. But the fact is that the pendulum can swing too far the other way. That is, I am concerned about that injured child or woman or man who has really suffered badly by rea-

son of malpractice of a physician. To say that that person has to live the rest of his life with a maximum of $250,000—which I think is the proposal of the AMA—is to me very distasteful.

It seems to me that a reasonable approach to this matter relates more to the question of some limitation as to the amount of legal fees and to the percentages that may be charged, but not to deny that individual, who is suffering so much, the right to collect whatever a jury thinks is appropriate.

I should point out in this connection that the total amount we are talking about as far as health care is concerned, paid to the insurance companies, is only one percent of the total cost. Now, that can be a pretty large amount. But the fact is, the total amount paid out to injured individuals, or to individuals who have suffered, is far, far, far smaller than the amount that the insurance companies have collected. I think some doctors have seen fit to form their own malpractice insurance groups and as a consequence have cut their expenses tremendously. There may be a need to do that for doctors on a national basis, and I think that would bring the costs down substantially.

Dr. TODD. Senator, there are a lot of truisms in the statement that you have just made, and it would be difficult to disagree with many of them.

On the other hand, the cost to society, the cost to patients of professional liability is higher than the dollars and cents in terms of withdrawal of physicians from doing risky procedures, leaving practice for other reasons. We agree that a patient who is injured should not be limited in whatever amount they receive to rehabilitate, to make them whole, to carry them through what might be a lifelong need for care.

On the other hand, we do not believe that unlimited awards for pain and suffering serve society well or serve anyone else well. We have a model in California that has been in existence now for several years, where there is a limit of $250,000 on awards for pain and suffering. Any economics that are necessary will be compensated. We are only talking about pain and suffering. They have a sliding scale on attorneys' fees. They have structured settlements, collateral source, technical matters of how the awards are made. It has worked well, and the malpractice premiums have stabilized in California. Doctors are feeling better about their doctor/patient relationships because they do not see as much of the adversarial—is this the patient that is going to sue me next—approach.

And probably most important, the public, those who potentially may be injured, have not risen up and said this is inequitable, or asked for it to be changed.

So we have a model out there that works, and I do not think, and certainly we at the AMA are not convinced that we have the right answer for professional liability yet. Our specialty society group has suggested an alternative dispute resolution that Senator Jeffords' State has written into their legislation in health system reform. We want to see how that works.

But until we find a better solution than we have now, we believe this program should include those provisions that we know to work and that have been found acceptable to the public.

Senator METZENBAUM. I think it might be advantageous for some of us to reason together with you and see where we go, rather than getting into a confrontation on the issue.

Dr. TODD. Absolutely.

Senator METZENBAUM. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Metzenbaum.

Senator Coats.

Senator COATS. Dr. Todd, has the AMA either conducted its own study or commissioned an outside study that will tell us the actual cost of what you consider excessive malpractice premiums? And also, you mentioned the intangible cost of not performing procedures, but isn't there also a cost of ordering extra tests in order to protect yourself from a liability standpoint?

Dr. TODD. Absolutely. Averages are dangerous to assume because if you take the average malpractice premium that is paid in this country, it may not sound too bad until you realize that in California, that has had tort reform, the average premium is $5,500; but if you go to Florida, it may be $190,000 before a neurosurgeon can first begin to practice. So there is great variation.

We have done some studies at the AMA that would suggest between $15 and $20 billion a year of health care costs go to defensive medicine, not necessarily tests that are unnecessary, but prior to processional liability concerns, a physician will be able to rely on his or her clinical judgment rather than having to have a piece of paper or an x-ray film to document everything.

An independent study done by Lewin and Associates end up with the conclusion that defensive medicine savings could be as much as $36 billion over a 5-year period. That is an independent study.

Those are the figures that we are working with. We know it is out there, but quantifying it becomes much more difficult.

Senator COATS. Linda, has the American Nurses Association done any similar studies relative to the—I assume most of the malpractice liability cost is picked up by the organizations that nurses work for; is that a correct assumption?

Ms. SHINN. In some instances, Senator. However, in other instances, nurses carry their own malpractice insurance. We have been very fortunate that, with the exception of some of the specialists like the nurse midwives and the nurse anesthetists, the insurance has been very affordable.

We have also been fortunate that by and large, our practices have been such that we have not been subjected to a great deal of litigation, although we have been subjected to some.

Senator COATS. You indicated support for the portion of the administration's plan because it provide for a considerably expanded role for medical services provided by nurses.

Ms. SHINN. That is correct.

Senator COATS. Have you assessed what impact this might have on your potential liability? I assume expanding the role moves you into areas of higher risk, and as a consequence, there might be a liability exposure that was not present before.

Ms. SHINN. We have given that a great deal of thought, and one of the things that we continue to uncover is that nurses' experiences by and large in patient satisfaction, patient compliance, patient adherence to treatment regimens and protocols, patient un-

derstanding of what is wrong with them and how to respond, has been very good. And while we certainly are sensitive to liability issues, I think the quality of the service we provide certainly moves in the direction of us not having had some of the experiences that physicians have had.

Senator COATS. I would like to get to the question of the cost shift. We understand now that the 37 million Americans, or whatever that number is, who are either underinsured or uninsured create a pool of cost that is shifted and has to be paid for by someone else in the system. Now, under the administration plan, we are going to provide those 37 million people with a basic benefit plan—in fact a basic benefit plan that is described as comparable to a Fortune 500 plan. I think it is natural to assume that that would substantially increase utilization of those services among those uninsured, because I think there is an understanding now that one of the problems is the uninsured only show up at the emergency room, or show up in times of crisis rather than for basic medical care.

Has there been any analysis by any of your organizations relative to the cost of the cost shift as it now exists versus the cost of providing the Fortune 500 basic benefit plan and the utilization that will result from that, and measuring those two? I ask that because the administration says we are going to get all these huge savings by avoiding the cost shift, but that obviously has to be measured against the utilization that is going to come under provision of those services for 37 million Americans.

Dr. GRAHAM. I think there are two separate parts to your question, Senator. One is the existing documentable shifts of cost that you could find in records today because someone presented himself for care, and that care was rendered, and he could not pay for it or he did not have an insurer, so the doctor or the hospital or somebody else picked it up. That is documentable. I have not see what those costs are, but that would be fairly straightforward.

What is more significant to us is the second level of cost-shifting, and that is when you give everyone a basic benefits package, and when that package is clearly tilted toward preventive and primary care, the people that we are seeing today where there is cost-shifting show up later, sicker, and in higher cost settings. They do not come to see the primary care provider. They do not get the prevention. The woman does not get prenatal care; the baby is born prematurely.

It does not take very many middle of the night, emergency room visits to run up a total cost that would keep you in primary care for 5 or 10 years, so——

Senator COATS. Oh, I understand the theory. I am trying to get at the numbers.

Dr. GRAHAM. I know of no one who has run the numbers. Once the specifics of the plan are delivered to you, and the assumptions are tangible, I think those are things that you will find organizations such as ourselves and the other consulting organizations being able to target more accurately.

Senator COATS. And just a final question that all four of you can answer if you like. With the global budgeting proposal—and some of you have spoken with different degrees of support or lack of sup-

port for it—measured against the increased utilization that will clearly come and may be justified on the basic benefits package—and we talk about basic benefits, but it is a pretty good-looking package—doesn't there have to come a squeeze somewhere in terms of quality and rationing? Can we have both? Can we provide that Fortune 500 plan to every American, put a global budget on top of it to hold down costs, and not squeeze? Something has got to pop out somewhere, it seems to me, and my concern is that it is quality and availability.

Dr. TODD. Senator, it seems to us that there are many things that can be done to make more rational the care that we give, the cost of that care, improve the efficiencies in how we do it, and get to see patients sooner before we have to pay for the high cost of prior neglect, to get the regulatory situation under control. There is a long way to go before we have to look at an arbitrary budget that fixes in places the inequities instead of addressing what they are. And I do not think anyone at this table would object to sitting down and trying to figure out what is an appropriate national budget for health care and then find out if we can meet it and, if we cannot meet it, why didn't we meet it—don't just ratchet it down the next year and make matters worse, but try to fix what blew the budget. That is where we are coming from, and we hope that that will be part of the President's ultimate package where we can sit down and reason together on how much health care we should give and how much it should cost.

Dr. GRAHAM. We are not alone in this universe. Germany, Japan, and Canada are all providing Fortune 500 care to every one of their citizens and doing it at less cost to their economy than we are. They all use some nature of global budgeting. None of us like to talk about rationing, partially because we are embarrassed by how much rationing goes on today. When the hearing is over, walk down to Union Station, walk around, and see how we are rationing care today. I think we can do a lot better.

Dr. LAWRENCE. I think the important thing in talking about global budgets is that we all be a part of that process of determining what that should be. I do not think that up front or in advance we can say that something has got to go, but we all have to participate in making that decision.

Ms. SHINN. I would not disagree, Senator, and in fact, this might be one place where the ANA can agree with the AMA, and that is, we have all got to come to the table in this discussion, and we have got to be able to provide this care to the people who do not have it or are losing it in a cost-effective way, and we cannot sacrifice quality. We have got to be able to come to those terms.

Senator COATS. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Wellstone.

Senator WELLSTONE. Thank you, Mr. Chairman.

Let me in 5 minutes just make two quick comments and then ask my two questions and then open it up for discussion.

First of all, Dr. Graham, thank you so much for your response to the important question raised by the Senator from Indiana. I was thinking to myself that we do not like to talk about the rationing we do right now, which has a very cruel effect, by income, by

employment, by race, by age, by where people live. And I think that, of course, is sort of the impetus for what we are trying to do together. I would like to thank all of you for emphasizing the importance of universal coverage and a decent package of benefits, which are the first two questions people ask. I have hardly met anybody yet who really talks about all-payer, no-payer, pay or play, managed competition, or single-payer. People do not just look in the mirror and ask, "Which one of those things am I?" but they want to know whether it is a decent package of benefits.

And thank you very much, Ms. Shinn, for emphasizing the mental health, substance abuse, and long-term care. I think we will have to fight very hard to make really sure that is part of the package of benefits.

Two questions. Is there consensus on the panel of a concern about choice? That is the third question people ask—will we have a choice of doctor? That is to say, with higher premiums—I am not talking about single-payer, American Health Security Act, which I am very committed to; we are all working together here—that is to say, with a higher premium on fee-for-service, or higher copays and deductibles—and I was asked this question both in inner city Chicago and, interestingly, enough, in small-town northwest Minnesota—will in fact that really be a choice if, in the very communities where many people may not expect to see these managed care operations, and fee-for-service makes more sense, we are going to impose a higher cost. Are you concerned that there may not in fact really be choice from the point of view of the consumer or, for that matter, caregivers?

The second question I have, and again, I will go back to the New York Times. One headline: "Health Industry is Moving to Form Service Networks." Another headline: "Humana Bets All on Managed Care." Another headline: "Many Patients Unhappy with HMOs." Another headline: "Hospitals Begin Streamlining for a new World in Health Care. Hospitals Merging and Closing."

Are you concerned that, as a matter of fact, the very quality of care that you want to give, that we may have a danger once more of not competition, but collusion, with micromanagement of caregivers, where the bottom line becomes the only line, and the kind of care that you believe you should provide to people is not there?

Those are my two questions.

Dr. TODD. Senator, we feel very strongly at the AMA that as the President's program is currently constructed, there will be a significant limitation of choice both for physicians and for patients—not as much are there might be, but it will be a limitation in terms of the plan that they choose—sorry. The choice will be they will choose the plan in which they wish to participate.

The problem comes when an illness strikes, or they wish to see another physician who is not in that plan. They will either have to pay an additional premium or perhaps all of the cost of having the choice of going to that plan.

For the fee-for-service, the deductibles and copayments, even though there is a limit to out-of-pocket, may price fee-for-service out of the realm of possibility for those who want to participate, just on the basis of economics.

We believe very strongly there are no benign incentives, whether you go to managed care or fee-for-service, and what we need to do is to make available to the public the information that will allow them to make their decisions based on what the economic consequences may be to them. So we think that we can improve the choice by some modifications, all the while realizing that patients do have to be involved in the economic consequences of their health care decisions.

Second, with regard to the giant insurance industries, the headlines you see this morning are not as bad as one in the New York Times some month ago, when Cigna——

Senator WELLSTONE. And there is also a quote from you, which I did not read, but which I thought was right on the mark. I do not know—I am agreeing with the AMA—I have to carefully reevaluate this. But go ahead. [Laughter.]

Dr. TODD. But in the New York Times section some weeks ago was the president of Cigna, a $19 billion operation, saying we are not in the insurance business anymore; we are in the health care business. And that scares the living daylights out of physicians, and the doctors scare the living daylights out of patients, when you think these are profitmaking operations, and they are siphoning money out of the health care system to pay investors dividends. We worry about this.

Senator WELLSTONE. It is a merger frenzy at the moment.

Dr. GRAHAM. We have a number of the same concerns that Dr. Todd has expressed; our position may be slightly different. What we see in the Clinton plan that leaves us most hopeful is the fact that it maintains pluralism. It is a plan which is structured to provide choice. Now, the question will be as it plays out, does that work. But the degree of choice in today's system is markedly diminishing, is getting less every day——

Senator WELLSTONE. I agree with that.

Dr. GRAHAM. —and I have some concerns about the status quo if you extend it 10 years in the future and see practically no choice at all.

So as in all things, when you look at the political side of it, I think it is going to be a relative measure. There can be problems with Mr. Clinton's proposal. The problems that we face today with the limitation of choice of patients with limited insurance options or no options, and providers, to me are on a worse slope than the slope described in working out the President's proposals.

Dr. LAWRENCE. Senator, we in the NMA do not take anything for granted. We cannot assume that there will be more or less choice, because for many of the patients, consumers, and providers whom our organization and the coalition represent, there is no choice today; there really is not. And what is described in the proposal would in fact be better. And I am not just talking about the ward attendant; I am talking about many African American physicians have very little choice, if you will, as far as where they will practice, how they will practice, and the same thing for their patients.

So we do not at this point in time have a fixed opinion that the choice options as described in the plan will be limiting. We do not see it that way. We are willing to wait and see right now.

Ms. SHINN. Senator, we are excited about the choice of providers that the President's plan envisions, and we think it would be good for Americans.

Senator WELLSTONE. I thank you very much. By the way, I fully appreciated your comment about the status quo and the lack of choice. I just want to make sure that it is pluralistic. I take it there is a concern about this merger and concentration of power that I think could be very bad.

Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Gregg.

Senator GREGG. Let me ask a couple questions, first, about community rating, which the Clinton plan proposes as one of its hallmarks, I guess. Isn't that inherently inconsistent with preventive care and with trying to encourage people to do what is right for their lifestyles? Doesn't community rating by definition mean that the person who smokes, the person who is an alcoholic—maybe using an alcoholic is a wrong example, because that is a person who is sick—but a person who abuses alcohol, someone who abuses drugs, the skydiver, the race car driver, end up basically being subsidized by the balance of the community because they all get charged the same rate?

So there is emphasis in this plan, or at least there is lip service given in this plan, to preventive and primary care, and yet if you have community rating, aren't you fundamentally undermining one of the key incentives for creating primary and preventive care, which is to say to people who smoke and people who do things which are conscious decision on their part to undermine or threaten their health, that, hey, it's okay to do that, because everybody else is going to bear the burden of your doing that, rather than penalize them?

Dr. GRAHAM. Senator, as I have always understood the economics of an insurance system, it is risk-pooling. Community rating is risk-pooling with a different set of rules than we have right now. In the health insurance industry right now, we have risk-averse behavior, and you have redlining, and you have exclusion.

I think your points are exactly correct. Any time you sell life insurance to someone who has a different genetic makeup, or who has different employment, you can argue that one low risk is subsidizing the high risk. In our view, the move toward community rating as part of insurance reform is a far more acceptable way within our communities to share the risks that we all face.

The other issue that we have to address as professionals and individuals that I commented on in my opening statement is some way to get a handle on the implications of individual behavioral choices. The current system does not do that well; the President's proposal really does not address it; really, none of the proposals do. I see that as an open agenda.

Senator GREGG. Well, community rating by definition does just the opposite. I mean, for you to make that statement is absurd. Doctor, that is probably the most absurd statement I have heard today.

Dr. GRAHAM. It is early in the day.

Senator GREGG. I mean, to come here and tell me that you are supporting——

Senator WELLSTONE. I thought it was eloquent.

Senator GREGG. If you are going to come here and tell me that you think there should be efforts to encourage people to act responsibly in the way they deal with their health, and then tell me that we should have community rating because it is a nice way to insure people, you are saying two things which are fundamentally inconsistent.

Dr. GRAHAM. I think, Senator, that really, the question is what is society trying to accomplish, what is the President trying accomplish. They are trying to get universal access to health care, and how do you do that in the quickest fashion? How do you get these people back in who have been redlined and who have been ignored by the system, and nobody has been there as a safety net to try to rehabilitate them.

You talk about destructive behavior, but we are going to have to deal with the mayhem on the highways, we are going to have to deal with the gun issues, the interpersonal violence. These are all things that if they get redlined out of insurance policies, the only ones who will be covered will be healthy people, and then those who need it most will not be receiving care.

I think we all understand the concern you have; it is how do you motivate healthy lifestyles. We just do not think redlining through insurance is the way to do it.

Senator GREGG. There is a big difference between redlining and community rating.

If I go to a doctor who is in an HMO, and under the President's plan, I pick a doctor and say that is my family practitioner, that is the family practitioner I like, and then I have a specialty problem—let's say I have a very severe injury or a severe disease—and I am advised that the best person in this specialty area is in some other city in some other State, maybe nearby. Under the President's plan, of course, as I understand it, once you are into one of these systems, you are not going to be able to get out of it. You are going to have to choose the doctors who are in that specialty, in that vertical specialty group.

So isn't choice significantly restricted here? Yes, you have the choice of the entry-level doctor, theoretically, the primary care provider, but beyond the primary care provider, the referral choice is dramatically restricted under this proposal.

Dr. TODD. As we understand it, yes, it is restricted economically in the sense that if the individual were to choose to go to somebody outside the plan, he would have to pay an additional amount. That may not be all bad, as long as that amount is not disabling, because as we have all said, there has to be some economic discipline. And indeed, in the quality studies and reports that will be required of the health plans, if they do not have competent, widespread, good physicians, people are not going to sign up for those plans. So that you do have the choice; it is just not a totally free choice.

Senator GREGG. That is a nice response in theory, but in practice, let us take an example. You are going to have single-State health alliances. One presumes that within those single-State health alliances, you are going to have three, four, maybe five ac-

countable health plans which are probably also going to be single-State accountable health plans. They may not be, but they probably will be. So if you are from New Hampshire or Vermont or Maine, and you have gotten an injury which is a unique injury—a child who has some sort of unique problem—you are going to be limited in your capacity for referral to the vertical group which is within that community of physicians. You are not going to be able to go to Boston where you may have the best person in the country, which is just a short drive away. So choice is going to be fundamentally and dramatically limited on a regional basis by physical location of where you happen to be.

Dr. GRAHAM. I think we may read an element of the plan a little differently than you do, sir. You have emphasized the word "unique." As I read the outline, the accountable health plans——

Senator GREGG. Well, it does not have to be "unique." It just has to——

Dr. GRAHAM. —well, therein lies the difference. As Dr. Todd has outlined, the alliances are responsible for having a full range of services that would be needed for the population in their area. If, for a matter of your convenience or choice, you do not want to accept those services even though they are medically correct and provided by a competent provider, then you have an economic disincentive to select another. However, if you——

Senator GREGG. Well, I would put to you that that is——

The CHAIRMAN. Let him complete his answer, please, Senator.

Dr. GRAHAM. Thank you, Mr. Chairman.

If you do come up with one of those one in a million—your child has a malignancy which is seen three times a year in the United States—as I read the outline, there is the flexibility for the accountable health plan to arrange for appropriate therapy, even though it may be across the country, and the plan will pay for that.

Senator GREGG. I think the first part of your answer reflects the fact that it is a dramatic limit of choice.

Dr. GRAHAM. Compared to today? I have wonderful health insurance from my association. If I want to go and see Michael de Baake, I cannot do it. I have to pay for it. Compared to what, Senator?

Senator GREGG. Compared to today. If you happen to be in New Hampshire, and you want to go to Boston to be treated, you can do it—today.

Dr. GRAHAM. It depends on your insurance.

The CHAIRMAN. Well, by and large, the employer makes the decision today for the employees, if they are covered. We have got to start learning about the elements of that question. The employer makes the choice today about what is going to be available to the employees. They are the ones making the choices today.

We are going to keep the record open for written questions. As I always say when I sit down and talk about this issue, it is always informative, and today was especially helpful and informative. There are clearly some differences among our witnesses on a variety of concerns about the specifics of the Clinton plan, but never before has any group so broadly representative of our Nation's providers stated so clearly unanimously and unequivocally that health

security for all people is essential and that the basic thrust of the President's proposal to achieve security is right on target.

Never before has any group of this kind committed itself unanimously to comprehensive reform, and never before has such a positive feeling and desire to work with the President on this issue been so clearly expressed.

I am more optimistic than ever about the likelihood that we will finally be successful in guaranteeing affordable health care for all of our citizens, and I look forward to further hearings we will be holding on the President's plan in the coming weeks.

Our hearing tomorrow will examine with Secretary Donna Shalala and other witnesses one of the most important components of the President's plan, preventive health.

Senator Jeffords?

Senator JEFFORDS. Mr. Chairman, I just want to thank Dr. Todd for his help and that of the American Medical Association over the years in helping me better understand the system.

I think we had excellent witnesses today, and I want to thank you all for coming.

The CHAIRMAN. Thank you, Senator Jeffords.

[Additional material submitted for the record follows:]

ADDITIONAL MATERIAL

RESPONSE TO QUESTION OF SENATOR HATCH FROM MRS. CLINTON

Question. Walk us through exactly how the global budget will work, explaining how the costs are going to be restrained without reduction in quality of care, choice, access, or technical innovation.

Answer. We do not have global budgets in this plan. We do have enforceable caps on premiums for plans covering the guaranteed benefits. This is an important distinction.

Global budget signifies a limit on total health care spending, including copays and deductibles, spending for noncovered services, and any other health care expenses individuals may incur by electing to pay for care privately, outside of their health plan. It is a much broader concept than that included in our bill.

A premium cap, by contrast, constrains the rate of growth in the price of health plans. In the Health Security Act, these caps are a backstop—we are confident that competition in a reformed market will bring down costs dramatically.

In the unlikely event the caps were triggered—here is what would happen:

Every noncomplying plan in a noncomplying alliance is subject to a reduction in its premiums to insure that total alliance spending is within the allowed target.

An alliance is considered to be noncomplying if the weighted average accepted bid exceeds the per capita target. A plan is considered to be noncomplying if its final accepted bid exceeds the per capita target for that alliance for that year.

The amount of the reduction is equal to the plan's proportion of the total excess spending that would be generated by all the noncomplying plans in the region.

In addition, each plan that is subject to the reduction reduces its payment rates to providers by a comparable percentage. This can be adjusted to offset any anticipated increase in volume that might result from lowering the rates.

RESPONSE TO QUESTION OF SENATOR KASSEBAUM FROM MRS. CLINTON

Question. How will experimental procedures like transplants be covered?

Answer. The National Institutes of Health supports clinical trials and other clinical research, which assist providers and third party payers in determining which clinical treatments are effective. The cost of investigational treatment is currently supported by research funds and by third payers who may cover the cost of routine care associated with investigational treatment.

NIH also supports efforts to evaluate treatment and prevention efforts through development of prevention and treatment guidelines and by sponsoring consensus conferences. The results of these activities can be used by the proposed National Health Board in updating the Comprehensive Benefits.

Experimantal treatments for life-threatening disease can be covered at the discretion of the health plan. However, even if the experimental treatment itself is not covered by the plan, the benefit package includes coverage for routine care during treatment, if such care would have been provided even if the treatment, if such care would have been provided even if the individual were not receiving an investigational treatment. All plans, together with their providers, will determine what is medically necessary and appropriate treatment on a case-by-case basis.

The National Board will be charged with monitoring advances in medical technology and will be able to revise the guaranteed benefits package over time to reflect these advances. Consequently, a procedure that is considered untested and experimental today may at some point become incorporated into standard, accepted medical practice. In such a case, the Board could direct all plans to include such a procedure in their covered benefits.

The CHAIRMAN. The hearing is adjourned.

[Whereupon, at 1:05 p.m., the committee was adjourned.]

PREVENTION AND THE HEALTH SECURITY ACT OF 1993: INVESTMENT IN GOOD HEALTH

WEDNESDAY, OCTOBER 6, 1993

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10:26 a.m., in room SD–430, Dirksen Senate Office Building, Senator Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Pell, Metzenbaum, Dodd, Simon, Harkin, Mikulski, Wellstone, Wofford, Kassebaum, Jeffords, Coats, Gregg, and Durenberger.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. If it is agreeable with the committee—I believe it is with our ranking minority member—I will introduce the Secretary, and unless any member has a profound statement, we will move right to hearing from the Secretary.

Madam Secretary, we are delighted to have you here, and we appreciate your tolerance of our delay in reporting out legislation in executive session. We very much appreciate your presence here today.

We are restraining opening statements this morning, so we look forward to hearing from you. We understand that the President's program includes extremely important provisions with regard to health promotion and disease prevention, and we look forward to hearing from you this morning. You are a good friend to so many of us on the committee, and we are delighted to welcome you back before our committee.

STATEMENT OF HON. DONNA E. SHALALA, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary SHALALA. Thank you very much, Mr. Chairman and members of the committee. It is indeed an honor to appear before you this morning to discuss the President's comprehensive plan for our health care system.

It is only fitting to appear before this committee, which has been at the center of so much of our national debate over health care, education, and civil rights.

The CHAIRMAN. Madam Secretary, just a moment.

Could we have order in the committee? We will ask our guests if they will be kind enough to be seated and restrain conversations.

This is a very important subject matter, and the Secretary is entitled to be heard. Thank you very much.

Secretary SHALALA. Mr. Chairman, as you know, it was your brother, President Kennedy, who first drew me into the public service as a member of the Peace Corps in the 1960's and helped inspire me to commit my life to the betterment of our Nation's most vulnerable. And under your leadership, this committee has kept our focus on the critical issue of health reform.

At HHS, we are enthusiastic about the promise of the President's plan for health care reform. We have worked many months on this plan and believe it will deliver what the President has promised, a system that provides every American with the security of health care that is always there.

The enthusiasm that we have is tempered by the knowledge that when you have completed this vital legislative process, it will be HHS, and other agencies, that must implement this program in rapid fashion so that the benefits and the savings we promise today quickly become the reality of American life tomorrow. It is a daunting task, but we look forward to the challenge.

We in the administration know that each member of this committee believes in the promise of health reform. While we have given considerable thought to our proposals, we also know that many of you may have other ideas that could work in tandem with our own. Over the coming months, I plan to be here on Capitol Hill to work with you, to consult with you, and, yes, to struggle together with you over the details of this legislation. And we commit to you now that we will listen carefully to your comments and your criticisms; we will study your ideas and work with you to fashion the very best piece of legislation that we can.

And when we are done, I promise you that my Department will be ready to share in the responsibility of implementing the law with all the urgency that it will require.

In his speech to the joint session of the Congress, President Clinton laid out six principles that have guided our work: security, simplicity, savings, quality, choice, and responsibility. As long as we adhere to these guideposts, we can create a system of health care that provides the kind of protection for the American family that we all desire. It has been heartening to hear how much agreement there is on these principles. If we can agree where we want to end up, the task of getting there will be made that much easier.

We want a plan that guarantees all Americans the security of health insurance that is both affordable and reliable.

We want consumers and providers to participate in a system that is simplified so that all players know what is due them and what is expected of them.

We want to deliver savings to individuals, to business owners, and, yes, to the Federal and State governments.

We want to preserve the high quality of our system that truly makes it the envy of the world, and we want to make sure it is available to all our citizens.

We want all Americans to have a choice of quality health plans that compete not on the basis of the slickest marketing campaign but on the basis of who offers the best policy to meet the needs of the people.

We want our people to have a choice of the thousands of talented health professionals who, once freed from the red tape of our current system, stand ready to provide top-quality medical care.

And, finally, we would ask all Americans—employers and employees, hospitals and physicians, insurers and drug companies—to take responsibility for their own health and the health of our system.

As you know, Mr. Chairman, we share your commitment to expanding our efforts to prevent disease before it strikes. Our comprehensive benefit package is rich with preventive benefits that we believe will save lives and money. For example, pregnant women will receive prenatal delivery and postnatal care, and their newborn babies will get well-baby care. Every American will receive regular physical exams with appropriate counseling and testing to detect a range of conditions that, if caught early, can be treated and eradicated. Women will receive preventive examinations including Pap smears, breast examinations, and mammograms. Children will receive all required immunizations, well-child care, full dental benefits, and coverage of eye care. This package of benefits vast increases the availability of fully covered preventive services for all Americans. Less than 50 percent of adults are now covered for routine physical examinations under traditional indemnity plans or preferred provider organizations.

Insurance alone does not always assure access to health care services. An enhanced public health system will offer protection against environmental pollutants, outbreaks of infectious diseases, and provide education to all consumers. This will include investments to establish provider networks, to renovate and expand the number of community and migrant health centers, and to expand the availability of enabling services as well as expanding the size of the National Health Service Corps. Through these efforts, we will guarantee that all children, no matter their family income or their geographic location, will have access to needed health care services.

Let me discuss a little further our commitment to quality because I believe that all of us here today agree that when it comes to health care quality is job one. Without a system that not just maintains but improves on the level of quality in our health care, we cannot guarantee security or any of our other principles.

From the beginning of our efforts, we were determined to preserve what is good about our health care system while fixing what is broken. For millions of our citizens, the current system delivers high-quality medicine from some of the most talented doctors, nurses, and other health care practitioners in the world. But when that quality is not universally available, the promise becomes a cruel hoax for those left out of the system. By providing universal coverage to all Americans, the President's Health Security plan will guarantee access to health care services.

And by establishing a comprehensive benefit package that runs the gamut from prevention to treatment, it makes sure not only that those who are ill get treatment but that those who are well stay well.

By building on an employer-based health care system that is familiar to our Nation's workers, the plan makes sure that we get to a universal system without first tearing down the system we have.

And by guaranteeing all Americans of a choice of at least three qualified health plans, it provides a choice of quality care.

By adding prescription drugs and long-term care benefits to our Medicare benefit package, the plan improves the quality of life of our elderly and disabled citizens.

And by blending our Medicaid population into this new system, it guarantees that a mother will not have to explain to her child why they have to travel many miles to a clinic when the practitioners in their area will not take "their" kind of insurance.

By eliminating much of the useless red tape in our current system, we allow our talented health care providers to concentrate on patients instead of paperwork.

And by curbing the astronomical rise in health care costs, we can make sure that all of us—employers, employees, government, and individuals—can afford to keep the quality we have.

But we do not rest with a simple promise of quality. We will create a system that oversees our medical care without interfering in the relationship between a healer and a patient. It will offer information and advice, not a new form or pamphlet. We will ask those who are involved in the system to grade our health plans, and that information will be made available to every person in the system.

In conclusion, Mr. Chairman, I know that we share a common vision, one of a health care system that is secure but not stagnant, simple but not simplistic, saves rather than saps our resources, gives us choice not chance, guarantees quality for all not a few, and asks responsibility instead of risk.

None of this will come easily, not here, not at my Department, not in our State legislatures, and certainly not in the board rooms and the family rooms of this country.

But I believe we can work together to make change work for all of us.

Each of us has come here to our Nation's Capital to improve the lives of the people we represent. Too often our efforts to achieve change are necessarily at the margins. Health reform presents all of us an opportunity to be part of history, to be able as we end this century to leave behind us tangible evidence of our ideas and our work.

It allows us to keep the promise of America. Health reform is about the people in our communities, the people that each of you represents. It is about our own children. It is about our friends, and it is about our neighbors. It is about big dreams, big steps, and big changes.

Thank you very much.

The CHAIRMAN. Thank you very much, Madam Secretary.

Given the numbers here, we will try at least in the first round to have 5 minutes, and then we will come back for repeated rounds and see what progress we can make.

As I understand it, there is only about 10 percent or less of the programs that are out there, insurance programs now, that provide anything close to what will be in the President's program. Those, as I understand again, are HMOs. Only one State, which is Massa-

chusetts, requires that every insurance policy have mammography and pap smears. So there is an enormous vacuum out there in terms of these kinds of services. Am I correct?

Secretary SHALALA. That is exactly right, and as my testimony indicated, this is literally twice as much as any major indemnity plan, regular insurance plan that we know of in terms of prevention services. This is an enormous step, Mr. Chairman, from the point of view of every American toward prevention.

The CHAIRMAN. And what are the co-pays and deductibles in this?

Secretary SHALALA. Well, for prevention services, there are no co-pays.

The CHAIRMAN. Oh, there are no co-pays. The administration's program is emphasizing the preventive, prevention; is that correct?

Secretary SHALALA. We put our money where our mouth is; in other words, ask Americans really to accept a plan in which the prevention part is free, encouraging people to keep themselves well, to keep their children and members of their family well, and then the acute care part of the benefit package introduces some co-pays.

The prevention piece is scientifically based, so we put together a package based on what the best evidence that we have to date is.

The CHAIRMAN. So what you are saying to every family, all the parents, is that their children are going to be immunized.

Secretary SHALALA. Yes.

The CHAIRMAN. What you are saying is that the pap smears and mammography are going to be available to people on a timely basis.

Secretary SHALALA. Yes.

The CHAIRMAN. What can you tell us about the numbers or the times in terms of mammography or pap smears?

Secretary SHALALA. Well, let me give you an example. The latest scientific evidence is that women over 50 ought to go to their physician and get a mammogram once every 2 years. That is the latest evidence.

However, we are going to ask the national board to define the high-risk group, and they also will be able to come in and have mammographies perhaps even more often. So we are going to not only cover the group identified by the best scientific information with 100 percent coverage in terms of co-pays, but we are also going to identify the high-risk group. The same thing is true for breast exams, and for Pap smears there is a different kind of schedule.

Whatever the scientific base is, that could be changed over time by the national board as they get more information.

The CHAIRMAN. So mothers who might have taken diethylstilbestrol and have higher incidences of cancer, those individuals that are at higher risk will be able to come in and receive those services.

Secretary SHALALA. Yes, and they will get free coverage, too.

The CHAIRMAN. Let me just mention testing. I am thinking now of lead paint poisoning of children. Many of major cities have that particular challenge. Will there be testing for lead paint poisoning, too?

Secretary SHALALA. There certainly will, and as part of our screening and part of the exams for our well-baby care strategy, we will include testing for lead-based paint. As you know, Mr. Chairman, I spent a number of years at the Department of Housing and Urban Development worrying very much not only about lead paint, but earlier we worried about lead in the air for children. So this kind of screening, this kind of preventative strategy ought to make a significant difference in the quality of life in this country.

The CHAIRMAN. Well, this is very important, and particularly the public health aspects of it. Because what you find out with lead paint poisoning, for example, is that the doctors treat these children in the emergency rooms, and very few, if any, hospitals have case management, and you have the doctors doing it instead of other kinds of social service management. That is enormously important.

You have a K through 3 program that some States have, birth to 3-year programs, which is, as I understand, very important and successful.

Let me mention one other item. On the service corps, the Public Health Service doctors, very few of them are dentists. As I understand it, there are only about 17 to 20. This is something that our neighborhood health center people in Massachusetts told me about.

I would ask you to give attention to that, if you are going to provide that dental care for children, that we have under the National Health Service Corps more dental slots because there are not a lot. But that is an important aspect, particularly in many cities.

Could you just comment on that briefly? What is this going to mean, for example, for children in regard to dental care?

Secretary SHALALA. We have included preventative dental services for children, and I think you will find that when the American Dental Association comes in, they are very enthusiastic about what has been included. They feel strongly that it ought to be targeted for children and, again, we ought to start with prevention. The point is to start early and to get kids into the right habits. So it is an enormous benefit and a big step forward for the children in our society.

The CHAIRMAN. Finally, as I understand it, there is a change in the policy for more pap smears and more mammography for those high-risk individuals. Is that right?

Secretary SHALALA. Yes. We actually went through it very quickly. If you read the package, it looks like all we are going to do is cover women over 50 as part of the prevention coverage. We have, in fact, added the high-risk group, and that definition will be done by the national board. That group will also be covered. That is terribly important because that group needs to be tracked very carefully. So they will be coming in for periodic mammograms.

We have not put a timing on that because their physicians working with them may decide they need to do it every year, not every 2 years. So it is the high-risk group plus every woman over 50. And, of course, mammograms are available for every woman. The difference is it is free if you are over 50, and if you are in the high-risk group, you will have a small co-pay depending on which plan you join if you and your physician decide that you want them more frequently.

The CHAIRMAN. Senator Kassebaum.

Senator KASSEBAUM. Yes, Madam Secretary, I would like to ask a bit about the prevention benefits and just how it was decided what would be included as prevention benefits in the package.

Secretary SHALALA. Well, there is a panel, a U.S. Prevention Services Panel, made up of distinguished experts. We relied on them to identify what is in the prevention package. In addition to that, like the other parts of the benefit package, the national board will be able to make changes as we get different kinds of scientific information about prevention.

The U.S. Prevention Services Board, also, their recommendations are consistent with those of the American College of Physicians and of the Canadian group that does the same kind of prevention strategy. So it is a group that are the experts in the field, and, of course, both the Department but the national board in particular will continue to review this.

Senator KASSEBAUM. Now, these are benefits, whether it is prevention or any other benefits, that are in the package that the administration will recommend and will come to Congress, and we can add or subtract from that package. Is that correct?

Secretary SHALALA. Senator Kassebaum, you are absolutely correct. The first cut of the package, of the benefits package and of the prevention package, will be done by Congress as part of the health care reform plan, as part of the Health Security Act. So I am sure that you will have lengthy hearings on every piece. I can just give you the background on how the initial draft was put together.

We are fine-tuning it still a little bit, so in 2 weeks when you see it, it will be our best work. Then we would be happy to discuss any part of it.

Senator KASSEBAUM. You said in your statement that all Americans would have a choice of at least three qualified plans. Now, it is my understanding that the basic benefits would be in each plan. Is that correct?

Secretary SHALALA. That is correct.

Senator KASSEBAUM. So they would be the same benefits in each plan offered in different ways as determined by the health alliance?

Secretary SHALALA. Well, probably as determined by the health plan; that is, the plan itself may decide to deliver the services in different ways. The comprehensive benefits package, which includes a prevention piece, will be in every qualified plan.

If, for instance, a plan decided that they were going to offer some supplementary benefits and sell them to members of the plan, they certainly could do that. But this is a very comprehensive plan, as you know, in terms of meeting—it is as good as any Fortune 500 company offers. With the exception of prevention, it is a lot more.

Senator KASSEBAUM. In the prevention section, you address school-based health clinics, I believe. Is that correct?

Secretary SHALALA. I had better check. I do know that we address school-based health clinics in our public health section of the overall plan.

Senator KASSEBAUM. Right. I did not mean as part of the benefit package.

Secretary SHALALA. Certainly the plans could work with schools if they decided to do that. But certainly as part of the public health section of the overall package that is coming up, we do provide some resources to work with school-based clinics. And that is part of the public health kind of outreach, making certain students get information.

Senator KASSEBAUM. I would guess that you as well as I support strong parental and community control of any school-based clinic.

Secretary SHALALA. Absolutely.

Senator KASSEBAUM. Do you in any way address parental involvement?

Secretary SHALALA. It is the position of this administration that it is parents, the local community, the local officials that should determine the content of what is offered in a school-based clinic. That includes the wide range of health or counseling services. Those are local decisions.

Senator KASSEBAUM. And just one last—no, I have two more questions. How much time do we have?

The CHAIRMAN. That is fine. You have enough time to ask your questions.

Senator KASSEBAUM. I believe the President's reform proposal earmarks some specific research initiatives. Is that correct?

Secretary SHALALA. Yes.

Senator KASSEBAUM. Would it not be better, let me just ask you, to perhaps leave it up to NIH or CDC recommendations for what type of research initiatives should be involved in a priority listing?

Secretary SHALALA. Those research initiatives that are identified in the President's proposal were identified by the National Institutes of Health and the CDC. We, of course, usually ask for the money and then do that later, but we felt that a way of clarifying the importance of research as part of the overall prevention strategy of the United States was to have the NIH and the CDC to identify those areas specifically in the prevention area that they thought were the top priorities.

Senator KASSEBAUM. And one last question because my time is running out, but you talked a lot about prevention, and I know the administration has suggested, of course, an increase on tobacco as a means of targeting an area which has contributed significantly to health costs. But why not then beer and wine and hard liquor?

Secretary SHALALA. I think that our explanation for choosing the cigarette tax at this point is, as Mrs. Clinton explained, when cigarettes are used as directed, they clearly lead to serious health problems. When liquor and beer are used as directed in moderation, they do not necessarily lead to health problems. And it was the health connection that led the President to that final decision.

Senator KASSEBAUM. Well, I find that a rather peculiar logic, Madam Secretary, but I know that it was given a great deal of consideration.

Secretary SHALALA. That is the best I could do, Senator. [Laughter.]

Senator KASSEBAUM. Thank you.

The CHAIRMAN. I thought you did just fine.

Senator Pell.

Senator PELL. Thank you, Mr. Chairman.

Madam Secretary, I am a strong believer in alternative medicine, new medical techniques. Thanks to the creativity of a member of this committee, Senator Harkin, we have an Office of Alternative Medicine. I was curious how its work is planned to be phased into the health plan.

Secretary SHALALA. One of the wonderful things about that Office of Alternative Medicine is it will over time change our attitudes and the kinds of medicines and approaches we use to medicine, that we use as part of health care. And as those things are folded in, the health professionals in the various plans, I am sure, will use them.

What we are doing with that rigorous new office is to do both the thinking and the review and to make more visible the results of the office. But I have no reason to believe that the health professionals in this country, on being presented an alternative way of improving the health of an individual, would not incorporate many of those proposals.

Senator PELL. Madam Secretary, you may have heard of a disaster we had in my own home city of Newport, RI, with a hospital that did many thousands of pap smears, and they were not correctly done, and a woman died. What can be done to make sure that instances of this are not repeated?

Secretary SHALALA. Well, I think that both quality assurance systems within the hospitals as well as within plans themselves certainly have to be put in place. And anything we can do in terms of the health professionals themselves putting in place quality assurance systems and risk-based systems will reduce those kinds of terrible experiences. And as we do more scientific research, as we do more prevention research, as we do more research on risk reduction, we will be better able to manage a whole series of tests as well as acute care procedures that we do in this country.

We need a lot more information about what we do and what the effectiveness is and a lot more data base kinds of decisions and controls over the quality of our system.

Senator PELL. Finally, I have a more general question; that is the expense. We spend twice as much as Great Britain on the health care per citizen, per person. The reason for that is they have rationing there where a man of my age, for instance, would not be given kidney dialysis.

How will you handle this question of keeping the costs down and still have the present philosophy carried out that everybody gets the maximum medical care?

Secretary SHALALA. Well, in two ways. I think that we want to make certain that we maintain a system of the highest quality. That means that the budgets of the rate of growth for this system, we have to be very careful as we make decisions, and there will be some controversy. There will be some challenging of us on whether we have made the system too tight.

Second, we honestly believe that with better quality assurance systems, with more information to our health care professionals, eliminating the paperwork that now both bogs down health professionals, our hospitals, and other kinds of providers. But there is an enormous amount of money in the system that can be focused on health care, and before there are any discussions about limiting

health care for any individuals, we need to get the resources focused back on health care.

We also believe that what we just talked about, prevention, helps to reduce the number of people that get sicker. That also frees up money so that we can focus on those that are very ill.

So I think we are a long way away in this country from that kind of an approach because there are just so many things that we can do ourselves to focus our resources more efficiently to improve the quality of health care for all of us.

Senator PELL. In view of the fact that the vast—I think it is about a third of the expenses one has in medical treatment is spent in the last 6 months of one's life, isn't there some way that that can be reduced?

Secretary SHALALA. Well, the decision about the amount of resources to be spent on an individual, no matter what their age is, is a decision that ought to be made by the family and by health care professionals, not by a distant government or a third-party payer.

What we need to do is to make sure that the resources that we have in this country that are labeled for health care, that we are willing to commit, are actually spent on health care instead of paper, so that that health care professional is really free to work through with the family appropriate decisions.

Senator PELL. Finally, I was struck by the TV program this last weekend showing how Cuba had pretty well contained, controlled, and is eliminating AIDS. Were you aware of that program, and is there anything we can do along the same lines?

Secretary SHALALA. Well, there certainly is a lot that we can do in this country about AIDS, about kids that get sick because they are not immunized, and these are preventable diseases. AIDS is preventable for the most part if people change their behavior.

Senator PELL. The basic thing they did was to quarantine everyone who had it.

Secretary SHALALA. Well, that is a pretty extreme proposal, and I suppose a country like Cuba could do something like that. I think that our strategy ought to be a public health, a public awareness, an individual responsibility strategy to begin to get people in this country to take more responsibility for their own behavior, to reduce the amount of risky behavior. And that is simply more consistent with our democracy.

Senator PELL. Thank you very much.

Secretary SHALALA. You are welcome.

The CHAIRMAN. Senator Jeffords.

Senator JEFFORDS. Thank you, Mr. Chairman.

I would like to make you aware of some of the idiosyncrasies of our system which make it difficult sometimes for us to do things. I am talking about committee jurisdictions and the budget, and I will get to the point on that. But right now, for instance, I served in the House on the Education and Labor Committee. We had jurisdiction over nutrition programs, school lunch, WIC, all of them, and yet when we went to try and do something, we would find that we had to show savings, that the savings would occur to the Ways and Means Committee because they had the social programs. So if

we were going to improve those programs, we would have to cut back on education in order to help improve nutrition.

In the Senate, the Agriculture Committee has most of the nutrition programs, except we have the one for the elderly. Senator Leahy, who has been a champion in the area of nutrition, along with Bob Dole, if they go to try to improve nutrition programs, they have to cut back the subsidies or the programs in agriculture.

The reason I bring that up is because nutrition in preventative health care ought to be a very important element of it, and I am sure you agree with that. But I just want to make you aware that when we get into this, unless you have a formula with the budget people to try and sift out what kind of savings you are going to get—and we do this in Congress—we are going to run into problems when it comes to bring the bill up.

I note that there is no mention of nutrition in your statement today on preventative health, and I do not think the plan really covers nutrition programs. I would hope you would agree with me that certainly nutrition is an essential element for the young and the elderly which could result in savings. I might ask for you to comment on that as to whether or not you intend to put nutrition programs in as an element of preventative health care.

Secretary SHALALA. Senator, first let me thank you for your leadership. We absolutely are committed to nutrition in a variety of different places in this health plan. There is some focus on it as part of our commitment to the National Institutes of Health. We need to know a lot more about nutrition, and it clearly is a preventative health research issue.

Second, in the public health portion, which you do not have yet, when the bill comes up you will see a commitment to national public health outreach efforts in relationship to nutrition.

Third, in the plan itself, in terms of the comprehensive coverage, of course a physician, a plan, can either refer a patient for nutrition counseling, make sure that everyone in the plan gets exposed to nutrition education. It is in the interests of the plans to do what they can to increase the amount of prevention efforts way beyond what is outlined in detail because that reduces the long-term costs for the plan in terms of individuals' health.

So I think that you will find the plans being energetic, and I think that most health care providers care very much about the relationship between nutrition and someone's health. It is not listed, though, specifically for prevention under the 100 percent coverage issue.

Senator JEFFORDS. Physicians and individuals have suggested to me that we ought to have an incentive program—I think the next panel will get into this—to reward people who have sort of lived the perfect life with no booze, no cigarettes, and they are up every morning at 6:00 jogging, etc, etc, by perhaps reducing their deductibles or increasing, rather, their deductibles, reducing their co-payments. What do you think about that?

Secretary SHALALA. Well, you know, that was one of the issues we struggled with as we were thinking about a comprehensive benefit package and whether it ought to apply to everyone or whether there ought to be differentials based on someone's behavior. I think that we concluded that there are enough incentives in the way the

overall plan is designed, and for businesses, the wellness clinics, the wellness strategies that businesses have now instituted, are in their interest because it increases the productivity of their workers. It makes certain that people do not miss days because of their own health. So within the American economy, in American businesses, they are reporting to all of us that it really makes a difference in terms of the productivity of their businesses for them to invest in the plans. So I think they still have a reason to invest in their own efforts.

Second, the plans themselves have good reason to strengthen even beyond what we have done the prevention efforts because anything they can do to reduce the number of people that have to be dealt with by more specialists in an acute care setting, anything they can do to get every child immunized, to deal with issues of obesity, for example, of individual health, will help that plan to become more efficient and to really be a quality plan.

So I think the incentives, both economic and social, are built into the plan without getting into lots of differentials among the plans.

Senator JEFFORDS. Thank you.

The CHAIRMAN. Senator Metzenbaum.

Senator METZENBAUM. Good morning.

Secretary SHALALA. Good morning.

Senator METZENBAUM. It is nice to see you again.

Under the plan, it is provided that the States would regulate the quality of the health care programs in the State or the health care plans. I am aware of the fact that insurance commissioners of the various States now regulate the health insurance industry. On a scale of 1 to 10, I would not give them much more than 1. They do a lousy job. They do a totally inadequate job. And as a matter of fact, generally with respect to the subject of insurance, the States, with some few exceptions, fail to meet their responsibilities to the public.

Now the Clinton administration is saying to us these health plans are going to be regulated; we are going to have the States do that. And whether its insurance department—which I would assume would be the case—or some other department, there is not much reason to think that they are going to do a very adequate job. My guess is they are going to play favorites. My guess is that the insurance industry is going to wind up controlling the plans and the people are going to wind up being at the bottom of consideration as far as health care is concerned.

By that time, the Clinton administration may be out; it may be 8 years down the road. But I am concerned about this whole concept of giving this regulatory authority to the States and why you are doing it.

Secretary SHALALA. Thank you, Senator, for a very good question. Let me talk a little about the philosophy, the underlying quality philosophy behind the plan.

We do not see the State insurance people or whoever is designated as actually being the single responsible entity for the quality of the plan. In fact, the President's health care approach is very much based on us building a quality assurance system in this country that goes way beyond the kind of State minimums on trying to determine the quality of a plan. In fact, the best States can prob-

ably do now is do a minimum kind of oversight, and as you have indicated, there has been a varying degree of quality between the States in terms of what they have done.

A first-class quality assurance program which makes the information public, a report card, empowering consumers—one of the reasons that we have asked that the boards of the alliances have consumers as well as employers is because the real quality assurance in the system, our ability to compare plans, is actually going to take into account a lot of new research and a lot of new information that we will collect about the plans: how many immunizations they have done, outcome measures in terms of the success of treatments by the plans themselves.

The health care professionals are helping us to develop some of these measures as are consumer organizations because they have had experience working with different kinds of plans. So I think we will not only have a data base but a new attitude about disclosure about the information that will compare plans. And we believe that the real quality assurance in these plans will be based on these data bases that will be developed, the kind of disclosure that will be made available, and the report cards that every person in an alliance will get that will allow them to compare their plan and the quality of its delivery system and the satisfaction that those in the system have about the plan.

Now, this, of course, is a very sensitive area for many health care professionals, but they are working with us to develop these quality assurance data bases. So while we will rely on the States to set up the systems, to draw the alliance lines—certainly the State will designate their lead hitter, like an insurance commissioner—that individual, the alliances themselves, and the consumers will have a lot more information. It really will be a different world.

Senator METZENBAUM. You have been involved with consumer advocacy groups during your lifetime. What assurance do we have that the consumers will have an adequate say? It looks good on paper, but how do we go about the mechanics of seeing to it that the consumers actually have this impact on the health alliances or the organizations that will be formed? And I am concerned that when push comes to shove, the special interest groups will see to it that their people are there, and the average consumer will not really have a spokesperson involved.

Secretary SHALALA. I think one of the wonderful things about the consumer movement in this country is that they really do come to the table, both with governmental officials, with elected officials, and are sophisticated enough to tell us in the legislation whether we have achieved a balance that both protects the professionalism of the system and leaves these health decisions to the health care professionals and the families, but simultaneously assures the consumer of due process. We have built in an ombudsman, for instance, as part of this system, an appeal process. And while I am not convinced when we come up here with our bill in 2 weeks that we have gotten it exactly right, I think every major consumer organization will be here explaining to both us and to you whether we have gotten it right and what their additional recommendations are.

I think it is a continuing conversation, but after we get the bill passed, even then we are going to have to continue to work with the system to ensure that this really, from our point of view, is a buyer's market, not a seller's market, that consumers and the citizens that participate in the plans really do have genuine power to do more than comment to keep the quality of their plans, to make sure that they are in a continuous improvement mode. And you have our pledge that we are not only sensitive, but we see it as the centerpiece of this approach.

Senator METZENBAUM. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. I thank the Senator.

Senator Coats.

Senator COATS. Thank you, Mr. Chairman.

Madam Secretary, I find that all of our discussion, including this morning, has been on what the plan will do, and I think we all appreciate the fact that there are areas of health care that Americans are not now receiving that are beneficial. You have outlined a comprehensive benefits package, not detailing every item, but you have already seen that even with a Fortune 500-plus plan on prevention, members are saying, yes, but this is not covered or that is not covered.

Now, you understand the political process and how it works. We love to give things away. We do not enjoy asking people to pay for them. Inevitably, it seems to me, the political process is going to kick in here, and the groups who are not covered will be lining up making their case for inclusion in the benefits package. And so even as generous as the administration's proposal is, my guess is that there will be tremendous pressure to increase even that.

That then leads us to the question of cost, which no one wants to talk about. It is great to be able to talk to people about what additional benefits they will be receiving, what additional services will be covered, how we will expand health care coverage to not just the 37 million Americans that are uninsured, but many, many other tens of millions of Americans whose plans do not now include all those items.

So my question is: What are the hard numbers in terms of making all this work in a way that we can afford to provide this coverage? For instance, the administration says that Medicare and Medicaid savings will total $285 billion over 5 years. Now, when you run those numbers out, that implies a 15 to 20 percent reduction in Medicare and Medicaid spending. That inevitably is going to have to lead to a reduction in benefits; otherwise, you cannot get those savings.

So on the one hand, we are saying we want to expand coverage, we want to provide new services, we want to add all these benefits that people are not now getting in the name of good health and prevention, and I understand that. On the other hand, we are saying we want to cut $285 billion out of Medicare and Medicaid.

I do not see how those two goals can be accomplished, and when I look at the way the political process works, I do not see how they can even begin to be accomplished. I would guess the AARP would be lining up outside our door very quickly. The leadership in Congress has already said they do not want to see any reductions in that.

So I guess it is left to me to ask the tough question: How do we pay for it?

Secretary SHALALA. Fair enough. I fully expect to be able to answer that question in detail when we come up with our financial package in a couple weeks with the legislation, but let me tell you what the elements are for paying for it and comment on the Medicare cuts, the so-called Medicare cuts, which is really slowing down on growth in particular.

I might preface, though, my comments by talking a little about the process that we went through, which, as you know, was very rigorous. In the process of bringing together all the actuaries and all of the people who do this kind of analysis at the national level, combined with the Urban Institute, we have built a model that even though all of you are going to be under enormous pressure because everybody is going to want in to the package initially, we have a model in which, as you are considering whether you should put something in or take something out, we actually will be able to give you a fiscal analysis of that.

If that is helpful as part of the discussion, because one of the things that happens is these packages get shifted around and you have no idea until the end what the actual costs are. And we will be available as part of the political process, because we have the model, to cost these things out.

There are three elements to the financing of the new plan, and we will both provide detailed briefings when we come up with the actual legislation as well as make our models available and our economic assumptions available.

First is that we are asking everybody to pay. This an employer/employee-based program that we have in the United States. We pay for health insurance that way. Most Americans who work get their health insurance through a contribution from their employer, and in most cases, they make a contribution themselves to their health benefits. And so we are paying for much of it by expanding the existing system and asking everyone to pay.

In the case of small businesses, we have indicated that we will be coming in to discuss the possibility of a subsidy plan to help small businesses as they adjust to paying for their own employees. But it is an employer/employee-based plan that we are building on the existing system.

Second, we are talking about savings, but we are taking the existing Medicaid program and the money we spend on that program, plus the State portion of that—and we need to negotiate a baseline with the States, a minimum, an effort by the States—and we are putting that into the plan to pay for the Medicaid people that we are folding into the plan.

In addition to that, we are, in fact, slowing down the growth—we are going to make recommendations to Congress, and I am sure we will have a long discussion about those recommendations—slow down the growth of parts of the Medicare reimbursement system for the most part from three times the rate of inflation to just under two times the rate of inflation.

Now, you may not like the specific items on the list. It is not a cap and that just throws to the Congress we are going to cap the system. We are actually going to give you a line item, line by line,

of the specific recommendations that we have of where we think we can slow down some of the growth in the Medicare system. So they will be very specific to try to slow down the growth in parts of the Medicare system. And those savings we put in as part of our effort to pay for this system, and that will help us pay for the new benefits that we are adding for the elderly population.

And, finally, we are adding a cigarette tax, the exact numbers for which—and we are asking those large businesses, over 5,000, to pay an assessment that will also go into the new system. But the vast majority of the money will come from extending the current employer-based system across every business in this country.

The specific numbers on that, we will come up in 2 weeks; we will show you our models; and we will show you our details.

Senator COATS. Well, now, Mrs. Clinton said last week it was going to be 2 weeks, and this has been going on since April. Is there a fixed date now for coming forward with these numbers?

Secretary SHALALA. I think I am operating off of—I cannot give you an exact date, but I do believe that we are winding up our final runs and the drafting of the legislation, and I have no reason to believe that it will not be 2 weeks.

Senator COATS. And so the $285 billion of savings in Medicare and Medicaid and, as you said, the reductions, the cutbacks in reimbursements and so forth, that will be specifically outlined for us in 2 weeks?

Secretary SHALALA. Not outlined. It will be detailed for you.

Senator COATS. Detailed.

Secretary SHALALA. And I want to be very clear that we are not coming up with outlines. While I cannot run through those numbers now because they are being finalized, it will be detailed.

Senator COATS. Will the numbers include the models that were used to——

Secretary SHALALA. Yes, and——

Senator COATS. And will that include increased utilization in terms of—we are taking 37 million people and we are giving them a Fortune 500-plus plan, as you said. Will that incorporate extra utilization to give somebody extra benefits obviously they are going to utilize?

Secretary SHALALA. We obviously will be prepared to detail how we expect to both—where the resources are going to come from to finance the system and where we believe we are going to get the savings from in the system.

Senator COATS. We will look forward to those numbers.

Secretary SHALALA. Thank you very much, Senator. I thought you were going to ask me about the Indiana-Wisconsin game.

Senator COATS. I was trying to avoid that. I was hoping the chairman would cut me off before you raised that. We will get you next year. [Laughter.]

The CHAIRMAN. As Madam Secretary knows, we had the Republican plan during the budget debate which would have reduced it $53 billion more than the administration's program. $53 billion more.

Senator COATS. That was some of the Republicans.

The CHAIRMAN. Some of the Republicans. I think the Senator voted for it. Didn't the Senator vote for it?

Senator GREGG. We did not have the detail of the models.

The CHAIRMAN. I think our colleagues voted for that as well.

As I understand, also—and then I will recognize Senator Simon—with the DRGs that went in in 1983, CBO has estimated that $60 billion has been saved. And according to the Rand studies, there has been no discernible impact in terms of quality.

Senator Simon.

Senator SIMON. Thank you.

As I understand, Madam Secretary, there will be, with the exception of these preventive services, a co-payment, and I think this is a desirable thing, though I applaud the idea of not charging for the preventive services. Our friends in Canada tell us the great mistake they made was not having a co-payment, so the system tends to be overutilized. And we are talking about a co-payment of $10.

Secretary SHALALA. Depending on what plan you pick, the co-payments can vary. You may go into a fee-for-service, for instance, as opposed to a closed-panel HMO. It is the choices that you have. But there will be co-payments for a variety of different services under the new plan. And they look like sort of normal co-payments for a generous plan.

Senator SIMON. Now, my concern, Illinois pays more on welfare—you are an expert in this field—than most States, and yet in Illinois the average family on welfare gets $367 a month. Now, if you have a $10 co-payment, let us say you have a sick child and you end up going into the hospital or to a physician's office three or four times. If you go four times in the course of a month, that is 10 percent of your salary. Is there any adjustment? How do we deal with that kind of problem?

Secretary SHALALA. Well, Senator, I think that in our conversations, both with the Hill and in our own re-review of that draft, that is exactly the kind of thing that many of you identified for us, and we do have that under review.

Obviously, if we would like everybody to take some responsibility for their own behavior, we would like at least some contribution. But we cannot put very poor families in a situation in which we are asking them for a substantial part of their income for a co-payment. So that is under review, and I thank you for noting that.

Senator SIMON. Senator Coats and others have talked about the cost factor. It seems to me as I review what you are going through, you have done a—you are trying to get those cost factors down as solidly as you can. But there really is going to be a lot of guesswork in this because we really do not know what is going to happen.

It occur to me as you put the revenue picture together that we maybe ought to do something that we have not done before in Congress, and that is provide a revenue source where there is some flexibility, where the administration, after consultation with the Finance Committee and the Ways and Means Committee, can have some flexibility so that we, in fact, meet whatever the needs may be.

I hope the projections are correct. I think there is a very real possibility, as you increase utilization of our health delivery services, that we may have some problems in this area. I just pass this flexibility idea along that I would hope you and our colleagues in the House and the Senate would consider.

Secretary SHALALA. We look forward to discussing that with you, Senator.

Senator SIMON. Thank you, Madam Secretary.

The CHAIRMAN. Thank you very much.

Senator Gregg.

Senator GREGG. Thank you.

Let me ask you one procedural question because I am not sure I understand how the actual process of the bill works. First let me say that I look forward, as I think the whole community does, to the detail that you reflected and the fact that you are going to give us access to the models. I very much appreciate that. That will be of big assistance to us figuring out what the numbers are.

Secretary SHALALA. And econometrics training along with them. [Laughter.]

Senator GREGG. I will just turn it over to somebody who claims to have had econometrics training.

If a woman goes into her doctor whom she has chosen—she has chosen an HMO, and she has a primary care doctor, and she goes to that primary care doctor for preventive medical checkups, a mammogram, for example, or a pap smear, and the benefits package says you can get one every 2 years if you are over 50—and I understand the Cancer Society's recommendation is that it be every year for mammograms—I am not suggesting that that be made part of the benefits package, but this is where my question comes in. If that woman says to her doctor, "I would like to have a mammogram this year, but I had one last year; therefore, it is not covered by my plan, it is not covered in the benefits package," as I understand the way this whole process works, her doctor cannot give her a mammogram and have her pay for it because her doctor cannot take balanced billing payment. She would have to go to another doctor in another plan and purchase that additional mammogram in the following year.

Do I misunderstand the way this works?

Secretary SHALALA. Yes, I think so, Senator. What is detailed in the plan that you are reading is the prevention part of the plan; that is, what we will provide 100 percent coverage for. That means that what is free is coming in every 2 years for a mammogram. But if a woman and her physician—if he decides it is medically necessary for her to have a mammogram, then it is covered. It may require a co-payment depending on the organization of that plan.

What we are reading now is the prevention piece that we are providing with no co-payment as opposed to other kinds of medically necessary services, which we could never detail, unless you really believe that the Government ought to write every detail down as opposed to a plan that makes medically necessary decisions.

Senator GREGG. No, that was not really the thrust of my question. I guess my question really was not that clear. The point I am thinking is that as I understand the basic concept that is being presented here, you cannot buy services from your doctor, is essentially what I am saying. You cannot go to your doctor in whose plan you are enlisted and buy the additional services that you want. You can buy services. You can go out and use cash to buy services, but you cannot buy them from your doctor. You have to

buy them from another doctor because your doctor cannot take balanced billing.

Secretary SHALALA. Let me say to you, if the example is a mammogram, if you go to your doctor and say, "I am really nervous, and I would like a mammogram this year even though I had it last year," and you and your doctor decide that it is an appropriate thing for you to do, that is covered. You will pay your co-payment, but that is covered.

If you, however, do not find a medical provider in your plan who thinks you ought to get something but you insist that you want to get it, one of the things that we are looking at now is something called the point of service option, and that is you end up going outside the plan. And the plans will have different rules about whether they will pay a portion of that or whether you can just go outside and get——

Senator GREGG. But do you have to go to another doctor, is my question. As I read the language—and obviously it is in general terms now—you would have to go to an entirely different set of doctors in order to get that treatment. You could not go to the doctor who you were enlisted with.

Secretary SHALALA. I just do not think that that is what happens. It is within the plan, and you pay your co-payment and you get the service that you want.

Senator GREGG. Well, maybe we could get some clarification.

Secretary SHALALA. Yes. Let me ask a prevention expert.

Senator GREGG. Well, that is okay. Maybe you could just drop us a line or something on it.

The CHAIRMAN. As I understand the question, you are talking about not medically necessary. So we are talking about something which is not medically necessary and how someone is able to purchase nonmedically necessary services.

Senator GREGG. From his or her own doctor.

Senator WELLSTONE. If you talk your doctor into it, medically necessary, you can receive it. If you do not——

Senator GREGG. You have to go to another doctor.

Senator WELLSTONE. No. The balanced billing means the doctor cannot charge you more than the regular fee. That is what balanced—that does not mean you cannot get the service.

Secretary SHALALA. That is what balanced billing means.

Senator WELLSTONE. So you have the services and the charges confused.

Senator GREGG. Well, maybe I do. Maybe I can get an explanation.

Secretary SHALALA. We will provide it in writing.

Senator WELLSTONE. I will send you a postcard.

Senator GREGG. Thank you. That would be great.

Secretary SHALALA. We will provide it in writing, but we think that the mammograms are covered. Someone might use a point of service option and go outside if they really wanted to go to another specialist or something else. But we believe it is covered.

Senator GREGG. OK. Well, on another topic, then, as I look at this proposal, you have a cigarette tax which represents about $100 billion, and you have deficit savings which represent $91 billion. So really the cigarette tax you are talking about—and I do not oppose

philosophically a cigarette tax. In fact, when I was Governor, I raised cigarette taxes. Really, the cigarette tax is going to create deficit reduction, is it not? It is not really going for the purposes of this health care plan?

Secretary SHALALA. I think I would rather wait until we have the final numbers. The cigarette tax could well be assigned to part of the plan.

Senator GREGG. But I mean as long as the only tax you have in the package raises $100 billion and you have $91 billion of deficit reduction, all you are really doing with your tax is creating a deficit reduction number. And that may be good politics, but it really does not have a whole lot to do with health care.

Secretary SHALALA. That could be true of part of the employer contribution, too. I mean if you wanted to assign part of the financing to deficit reduction. I think it is safer for me to say at this moment, since I cannot confirm your $100 billion number out of the cigarette tax, for us to wait and see what the whole package looks like, what the deficit number is. But, you know, the deficit, if there is a deficit, a substantial deficit piece in this, it could be assigned to any part of the financing. It is a coincidence that the numbers look close together.

Senator GREGG. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Dodd.

Senator DODD. Thank you, Mr. Chairman.

Welcome, Madam Secretary. I would note just as a preface that when you were president of Hunter College in 1986, some 7 years ago, you wrote a report on the needs of America's poor children, and as part of that, you called for a comprehensive initiative to provide preventive medical care for children. So you are not a newcomer to the issue, and it is with that preface that I would like to ask three questions, two that relate to children, and a third that deals with the elderly.

I happen to subscribe to the view that there is no better way to address the cost of health care—not throng Medicare or Medicaid, or through a cigarette tax—than prevention. This has been demonstrated over and over and over again, and I think the President was accurate in talking about the importance of personal responsibility, of how people conduct their lives, and obviously, of the investments we make early on.

We in Connecticut have full funding for immunization programs; you do not have to pay a nickel for them. The State picks up the cost, and yet we only get about 65 percent of the 2-year-olds. So despite the fact that we have universal availability for child immunizations, we are not achieving the desired result. I might add that a lot of effort is going into this.

I would like you to first address the question of how we are going to achieve fuller coverage in the immunization area, just some practical ideas.

Question No. 2 relates to a second group of children. Everyone talks about the importance of infants, but children ages 6 to 19, which includes adolescents, under the draft report as it is right now, will receive only five clinical visits between the ages of 6 and 19. The American Academy of Pediatrics and others are rec-

ommending at least twice that number of clinical visits for children in that age group, because of sexually-transmitted diseases, teenage pregnancies, violence, and a lot of other issues.

I realize this is a draft report, but let me just tell you how I feel about it. I think the American Academy is absolutely correct, that we are doing a tremendous amount at the early ages, but that 6 to 19 is a critical age group. And again, given the fact that prevention will save billions of dollars, we can do a better job in that age category. It seems to me that five clinical visits is painfully short of what needs to be done.

My third question relates to older Americans and prevention. A paper in the American Journal of Preventive Medicine reported that Medicare currently pays for only 4 of the 44 preventive services recommended for the elderly by the U.S. Prevention Service Task Force. We have raised that number slightly by covering flu vaccines. I would like to get from you, as the third part of my questioning, what we are recommending with regard to preventive services and the elderly. This again goes back to the basic point that there is no quicker way to save taxpayer money, it seems to me, than in this particular area. I realize we are dealing with a draft report, and you are seeking recommendations and ideas in this regard, but I am utilizing your presence here to emphasize the significance I place on prevention, particularly in the area of children, but also noticing what was recommended in the area of the elderly. I would be interested in your response.

Secretary SHALALA. Let me start with the immunization and the outreach. I have spoken to this committee before, and one of the things I said was that as we mounted the national immunization campaign, one of the reasons why we wanted to provide the vaccinations to physicians and not simply through community health plans is because we were well aware of the need to get that connection between the physician and the family very early on—well-baby care and all the other things that need to take place.

What the President's plan in draft form now does, going back to the quality assurance issue, is one of the things that we will measure those plans by is whether they have gotten all the kids immunized who are in the plan. They will have an incentive as part of their quality management system, not only an incentive to get everybody into their prevention programs because that will help them to hold down costs, but also because it will really make them a quality plan.

So as we have talked about what is going to be in the report card, I can guarantee you the percentage of preschool kids who are immunized is going to be in that report card.

Not only will the plans themselves be doing outreach on their prevention services because they are going to be measured by them, but our public health initiative will continue our national efforts to remind everybody about the range of prevention, in particular immunization, where we need to get young people in.

Second, on the whole issue of children's services and whether we should focus more attention particularly on high-risk kids in the prevention area, one of the reasons the plan still is in draft is because of these kinds of consultations, and we are, as we did on the mammograms and on the breast examinations, continuing to look

particularly at whether we ought to cover high-risk groups, whether it is women in terms of mammograms on the prevention side so there are no copayments, or whether it might be expanding some prevention services for children. We will look at that very carefully.

On the elderly and prevention, I absolutely agree with you, and our goal is to substantially beef up the Medicare program in relationship to prevention. We have mounted, as you know, a national campaign—I just did two more TV spots yesterday—and you will be interested that Fernando Torres-Gil, the new assistant secretary for aging, has done them in Spanish for us—telling our elderly population that they need to get flu shots, they need to get them now, they are free under the Medicare program. And the press has been tremendously helpful in getting the information out. I even told the President to call his mother—I do not know whether he did or not, but the point is I have told everyone to call their family members.

As part of this national campaign, we need to personalize that, but increasing attention to prevention. I was at senior citizens' homes' activities over the last 2 weeks, and in every group what we talked about was prevention. As we get the institutions that work with our elderly population to do more about prevention, to get them their flu shots, pneumonia shots are going to be terribly important; so, absolutely.

Senator DODD. Thank you very much.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF SENATOR DODD

I would like to thank Secretary Shalala and our other witnesses for being here today to talk with us about the important topic of preventive medicine and how it fits into the President's health care reform proposal.

Secretary Shalala has been a leader in this area, and she has not simply happened upon it recently. As president of Hunter College in 1986, Dr. Shalala wrote a report on the needs of America's poor children, and part of that study called for a comprehensive initiative to provide preventive medical care for our children.

The need for preventive care

The fact that we are here, seven years later, discussing this problem again is frustrating. Frustrating because we know the value of preventive medicine, but we fail to act on what we know. Like Secretary Shalala's analysis in 1986, countless reports have shown that preventive medicine is good medicine and good public policy.

By stopping illnesses before they happen, or catching them in their earliest stages, we can stave off major health problems. This often ends up saving money in the long run. But despite the demonstrated need for preventive care, it remains the neglected stepchild of our current health care system.

Less than four cents of every health care dollar we spend goes to preventive medicine and health promotion. To put that figure in perspective, we spend nearly a quarter of every health care dollar on administrative costs. We are spending more than six times as much on paperwork for and about sick people as we are on trying to keep people from getting sick in the first place.

The Clinton plan and preventive medicine

I know I'm preaching to the choir here, and I applaud the administration for stressing the importance of prevention in its health care proposal. Coverage for physical examinations, mammograms, cholesterol screening, child immunizations and other preventive measures are all included in the president's plan. Like other parts of the proposal, we will be working out the details in the months ahead. For instance, how often should people be eligible for these tests and examinations?

All of the fine print will be resolved, but the principle is the critical thing at this point, and the principle has been clearly stated: prevention is important. For that, I commend the administration.

Child immunizations

I am particularly interested in the issue of prevention because it is so important to children's health. I think one compelling example illustrates this point. Immunizing children against measles is an excellent case study in how simple, preventive medicine can protect a child from an unnecessary disease and save significant amounts of money down the road.

Despite the overwhelming evidence in favor of measles vaccinations, the United States has what can only be described as an appalling record in this area. The measles immunization rate for one-year-olds in the United States puts us below India, below Zimbabwe, below Iran, below Vietnam, and below Mongolia.

Here is a situation in which it can be proven that a small investment in preventive medicine would save money down the road. It is estimated, for example, that the measles outbreak of 1989–91 in this country led to more than 44,000 days of hospitalization. Each 1,000 cases of measles during this epidemic cost $3 to 4 million in medical expenses.

Yet despite the strong case for action, despite the knowledge that inaction leads to needless illness and unnecessary expenses, our system fails to take the simplest of preventive measures.

Child Health Day

This past Monday was Child Health Day, and to mark the occasion the American Health Foundation released a report on child and adolescent health in this country. After reviewing the United States' performance on a wide range of preventable childhood health problems—from substance abuse to lead poisoning, from sexually transmitted diseases to child abuse—the foundation gave us a grade of C minus.

We are the world's one remaining superpower, we have an economy that, despite its problems, remains the envy of the world. Yet we can do no better than a C minus when it comes to looking out for the health of our children. That is a sad statement on our priorities as a nation.

Youth violence

One of the major preventable causes of medical problems in children is violence. I have been doing my best to bring the crisis of youth violence to the attention of my colleagues this session. Four

thousand children every year in the United States are murdered. Thousands more are seriously hurt in violent incidents.

The statistics tell us that today, as we gather here to discuss ways we can prevent illness and injury, 12 children will die victims of violent crime. Nine out of every ten murders of young people in the industrialized world happen in the United States.

Again, I am not telling the Secretary and our other witnesses anything they don't already know. I commend the administration for recognizing that violence in our society is a major contributor to our health care crisis. And I look forward to continuing to work with Secretary Shalala, Attorney General Reno and others in the administration to address this terrible problem.

Conclusion

I would like to close by again commending Secretary Shalala for supporting an approach to health care reform that is not limited to treating disease and injury after they happen but to trying to keep them from happening in the first place. Thank you.

The CHAIRMAN. Thank you, Senator Dodd.

On Senator Dodd's point about the public health delivery, we had a hearing in Boston, and we have an excellent program in Massachusetts. It costs about $600, and they track people almost 90 percent in terms of TB. If you go to Harlem, where they are able to track 10 percent, it costs $20,000 to treat. So this kind of investment in terms of the outreach aspects has enormous cost implications.

Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, thank you.

Madam Secretary, I would like to have time to ask you two questions. One is on defining health, and the second is on universal coverage.

I recently discovered that if I contribute to the Combined Federal Campaign, it is not really a United Way, where the money goes to all the deserving organizations; it goes to organizations that are designated for specific purposes. So this morning at 7 o'clock, I was with a little group of 60 to 80 people that a congressman brings together every Wednesday morning in the new library in the heart of the city, and they pray for the people of the city, and one of their organizations is called People's House—and if there is any television on me, it is CFC Number 7390. People's House has been put together by a Democratic Member of Congress and a lot of other people to try to respond to the desperate needs of people who live in this community.

This community is not that different from other communities in the country. At this little group this morning, one of the people who was there said, you know, there ought to be a sign for a lot of people in this town. When you come into this town, it says "Welcome to Washington, DC, Mayor Sharon Pratt Kelly," etc. Then there ought to be a little sign, out of Dante, that says, "Enter here, all ye without hope," because in this community, there are thousands and thousands of people without hope. You need only pick up our newspapers and watch our television. And it is true in Minneapolis, and it is true in Bridgeport, CT, and it is true all over the country.

So my first question really deals with the issue of health, broadly defined. I know we have all this concentration on health insurance for everybody and so forth. And all of the discussion this morning, as I know it—and I am also running down to a Finance Committee hearing—has been about prevention and wellness. We have not talked a lot about poverty, and we have not talked about homelessness, and we have not talked about all the many other generational driving forces that adversely impact on health in this country.

So what I would like is either your observations about what the President said about increasing personal responsibility or your observations about how a national Government's public health programs, which have not succeeded in doing anything other than slowing down, perhaps, the incidence of violence and self-abuse and abuse of others, and everything else in this country—how a national health care system is going to do something for the real serious health problems that a lot of people in this country face.

Secretary SHALALA. Well, that is a very thoughtful question, Senator. I am not sure I can do it justice in a few minutes.

This is not simply a narrow health program for a narrow, limited group of people. The significance of the program—and while I think the prevention piece is key—is the comprehensiveness and the coverage for every American. What this does is significantly raise the quality of health care for the poor as well as for the rich, for working Americans.

It does deal with issues that have ravaged our communities, whether it is AIDS—if you have AIDS in this country, you are more likely than not to have either lost your insurance or are unable to get insurance—so it is the broad coverage, the access for everyone of a comprehensive program, but it is the message that that sends. It is not simply that everybody is going to be able to bring in their children to get immunizations, but it is a message that in this Nation, we believe that the quality of life we are going to invest in in terms of giving people a real chance to lead healthy lives. But they are going to have to do some things. They are going to have to take some responsibility for their own behavior, whether it is risky behavior. They are going to have to share some of the cost. They are going to have to take responsibility for their kids to get them in.

We are going to get a top-notch professional, a primary care physician, to work with them and their families, but we are also going to expect them to not only share economically in the responsibilities but to share personally in the responsibility for their own health and for the health of their families.

So it sends a fundamental message about what I think the country is about. It also has broader underpinnings. I think we see the link in the Department between everyone getting coverage, which is wonderful, but also the connection with public health, which is far broader than giving everybody access to vaccinations or to mammograms. It includes issues like security——

Senator DURENBERGER. Madam Secretary, I really appreciate your response, and I do not mean to cut you off except that I have gotten a little sign that says my time is running out.

Secretary SHALALA. OK. But it includes issues like violence, from our point of view; it includes issues like poverty. And there are

many people who are poor in this country who cannot get up and get off of poverty and go to work because they do not have health care. So the connection between working and health care, the connection between domestic violence and our ability to put programs in place——

Senator DURENBERGER. And we have had this discussion before, and I think in this committee in particular, everybody is much more sensitive to the issue than they are in other committees. But I am leading up to another question and observation which is that everywhere I go to speak in large groups, I am asked this question about where is public health, and where is this insurance plan. And I just caution you about too much expectation that an insurance plan is going to be able to cover all of the things that are really wrong in our communities.

We are in the third generation of poverty, and sort of a loss of conscience and whatever else it is in this community and so many other communities around this country, and it is going to take a bigger effort than that.

The problem for a lot of people is there is $903 billion this year, one-seventh of our economy that is just going into the doctors and the hospital part of this system—so what is left for the poor? I mean, what is left to deal with these problems?

Just saying that we are going to get rid of Medicaid, and we are going to have a low-income voucher program, is not really going to meet those expectations. And I am not sure—and this is my question—I am not sure that until we can demonstrate to the American people that this new system of getting care to people at a lower price, bringing that 14 percent of GNP down, is actually going to work, that we are going to have the resource commitment to fund it universally, because so many people realize there is much more to this problem than just insurance.

So my question is one I asked the First Lady also last week, and that is why don't we demonstrate the value of whatever new system we can all agree on, whatever these rules are, and begin to let the system work from community to community before we insist on universal coverage all over this country, when you have such a disparity in what the systems are producing today by way of quality and cost? Is there an easy answer to that question?

Secretary SHALALA. Well, the easy answer is that this system is based on universal coverage. If you are really going to both have an impact on poverty for people and see the link between health care and welfare, for example, then universal coverage is very important as a key part. But I would argue that the Congress has already taken enormous steps, and if you link this national effort for health care reform to what this Congress has done on the earned income tax credit, those are two enormous steps for the working poor, for example, in this country.

I would argue that we have tried all the incremental pieces. We have tried to link all the pieces together, and unless we are prepared to take a giant step in health care, we not only cannot have an impact on poverty, but we cannot have an impact on our economy. One of the problems the economy has in creating jobs is that the health care costs cannot be planned for by most of our businesses.

One of the problems that people on welfare have is that if they get off welfare in this country and take a minimum wage job, they lose their health care.

So that the only way that I know of to deal with issues like poverty in a signal and a significant strategic way to deal with issues like poverty is to understand the linkage between health care reform and our economy, and some of the other things that we are doing. If you see that, then you see what an enormous step this is to deal with other kinds of fundamental issues like lifting people out of poverty.

Senator DURENBERGER. Thank you.

The CHAIRMAN. Thank you, Senator Durenberger.

Senator Harkin.

Senator HARKIN. Madam Secretary, again my compliments to you for taking this on and for focusing your attention on prevention. That is what this hearing is supposed to be about. As you know, I feel very strongly that unless we really have this as the underpinning of our health care reform, I do not care how you fund it or who pays or whether it is single-payer, multipayer, or whatever it is, if we do not really have prevention as the underpinning of it, we are just reshuffling some chairs, and we are really not going to accomplish much.

So I have four things that I would like to cover with you, and they all deal with prevention. The first is children. It has to do, I guess, with the immunization problems we have had. I mean, we can get the money for immunizations, but we really cannot get people in. These young children whose mothers are, in most cases, single mothers are barely literate and low-functioning, and they really just have no incentive to bring them in. I am wondering again are you going to build into this plan both the carrot and the stick approach—in other words, incentives to get these people in on the one hand, and if they do, they see some tangible benefits; on the other hand, if they do not, they may see some tangible losses.

I am, again, hopeful that this will be built in and not just left up to the plan to do it, because I fear that the plan in terms of trying to hold costs down will think of the immediate cost and not think of the long-term benefits. That is what Senator Kennedy was talking about in terms of the costs. So I hope that will be built in.

Second, prevention in schools, or school-based prevention. I just read an interesting statistic in Working Mother Magazine—you may wonder why I am reading Working Mother Magazine, but I was——

Senator MIKULSKI. I am taking note of that.

Senator HARKIN. Less than one-third of the children in elementary school now receive some physical exercise or physical education during the day. Again, I know you are Secretary of the Department of Health and Human Services, and this gets into the Department of Education, but I hope we can break this down in some way so that in the health care plan that we are looking at, we can build in incentives for school-based physical exercise and physical education. That will, again, give rewards or incentives to kids to do this.

One of my kids is in elementary school in Fairfax County, and they have physical ed every day. If they meet certain arm, leg,

heart, lung, and weight/height goals, they actually get grades for it. It is built into their grade base, which sends them a signal that not only do they have to prepare their minds, but they have to prepare their bodies also. It is that kind of thing that I hope will be built into the health care plan.

The third part of that is the school lunch program. There is just too much fat and too much sodium in the school lunch programs. Again, I know that is not under your jurisdiction, but it sure is part of the health problem in America today. These kids are getting too much fat and too much sodium in their school lunches. Again, this has got to be built into this health plan.

So I just wonder if those three items—first, incentives for low-income mothers to bring their kids in, or a tangible loss if they do not; second, something that would promote physical education and physical exercise in elementary schools; and third, focusing on the school lunch program—are these things that are being thought about in a way that will not just be an ancillary thing under the health care program?

Secretary SHALALA. Senator, let me answer it at one level, and then continue the conversation with you. The point that you are making, which is so good, is that if you are really committed to prevention, it is not just prevention services as part of the comprehensive benefit package, but that this country has to move to a different level, whether it is the Department of Education or the Department of Transportation. The new Secretary of Transportation is very interested in what role that Department can play in relationship to prevention, whether it is seatbelts or other kinds of designs. The Department of Agriculture has already initiated some things in relationship to what is going into the meals that our kids are getting. The Government of the United States itself, the Clinton administration, has to see all of these connections way beyond what is in the comprehensive benefit package——

Senator HARKIN. That is very true.

Secretary SHALALA. —and it is that kind of strategizing that we are indeed doing. In fact, one of the three themes of the Department that is not just focused on health reform is prevention. So it is not only prevention for us under the assistant secretary for health, but it is also the assistant secretary for children and families, the head of the office of aging—it is stretched throughout our Department so that everyone sees prevention as one of the major strategies. That is exactly the way we are thinking. We are thinking about what the supporting pieces are that make that comprehensive benefit package work.

Senator HARKIN. Yes, because I think a lot of people do not think about the school lunch program as being part of a national health care system. I say it is vital to it, vital to how these kids start, what they eat and how they eat when they are in grade school.

So again, I just hope that that is part of this package.

Second, workplace prevention. Employers are going to pay 80 percent, employees 20 percent. Some companies have good wellness programs for their employees where they give incentives to their employees—if they quite smoking, if they meet certain goals, cholesterol screening, blood pressure, that type of thing. If a company has a wellness program which can meet certain goals set out by the

national health care board, I think they should also get an incentive—may be a reduced rate; maybe they should not have to pay so much in, a little cut rate, to encourage and give incentive to businesses to set up wellness programs, to get a discount, for example. That is, again, part of prevention.

Now, again, you run into the costs—well, we lose money coming into the system. Again, that is what I am afraid of, that we are going to look at the up front costs so much that we are going to forget about the downstream benefits of putting more into prevention.

Third, as you said, the national board would make recommendations on preventive measures based on science. Well, this gets into my whole thing about research and that we have to focus on research. I will make this point publicly again as I have to you privately many, many times. We had a big debate here on the superconducting super-collider, and all of the benefits that we were going to receive from it—ephemeral at best, maybe 20, 30, 50 years from now—but there is one project that I think is so much more important than the collider or the space station or anything else, and that is the Humane Genome Project. That, we are going to see tangible benefits from immediately. Dr. Collins tells me we can finish that project; we can map it and sequence the gene by the year 2000 if we have enough money.

Now, what does that mean? Well, cost savings. Getting back to breast cancer, for example, not every woman needs a mammogram. Some women do not get breast cancer. If we can find the genetic markers that indicate which women are susceptible to breast cancer, those that are not do not have to get mammograms every year. Those who do should, at an earlier age, maybe 34, 35, something like that. The cost savings from that alone will be remarkable.

So that is just one area, and we can do this by 1997, 1998. But unless we put the money into the Human Genome Project, we will not have that, and we will not be able to realize those cost savings. I know you agree with me on that, but I just wanted to make that point again publicly, that we are not getting the money into the Human Genome Project that we ought to be getting into it. We can finish it, and we will finish it someday; if we just dribble along now, we may finish by 2020 or 2030. But we can finish it by the year 2000 and map and sequence the entire human gene. What that will do for us in terms of preventive health care will be remarkable.

Finally, on alternative medicine, just to pick up on what Senator Pell said, the Eisenberg study showed that more than 50 percent of the American people at some time during the year use some form of alternative medicine. By and large, a lot of that has to do with gateway procedures in terms of prevention or forestalling and putting off more serious types of intervention programs.

I recommend to you a study that was done and just released by the Province of Ontario. Their health director just issued a study on certain alternative health measures, and I would recommend that to you. And again, I hope—I do not know what is going to be in the plan, but if it is just going to sort of obliquely refer to alternative methods and practitioners, I think it is going to be deficient.

I think it has to incorporate them fully into the plan, and I hope it will do so.

Secretary SHALALA. I appreciate your comments, Senator. We talked a little earlier about the wellness and whether there should be a discount on the plans. We had, in our early draft, rejected that because we felt that having a wellness plan was in the economic interest of the business in terms of the productivity of their workers, and that is was more complicated to administer something where there were various discounts in the comprehensive benefit package, and it keeps their workers' comp costs down, so there are economic incentives for wellness plans. But certainly, we are always open to ideas, and we should keep the conversation going about the whole range of issues.

On research, you know that I agree with you that the best kind of prevention strategy for this country is fundamental research. The Human Genome Project is expected sometime this year to give us a breakthrough in breast cancer research where we will be able to more carefully identify those women who are at high risk. But it also reflects health and why health is a different business; that you can have a scientific breakthrough which has enormous savings, and it is not the normal kind of service industry, and if we do not keep our investments in research, we are not going to be able to both contain costs and improve the quality of health.

So I see research as part of the prevention strategy of this country, and I know that you agree with that conclusion. All I can say is we will do our best.

Senator HARKIN. Well, again, I hope those who are drafting this plan see it your way.

Secretary SHALALA. I also want to thank you, Senator, for your enormous and very quick work on the conference committee on our appropriations. We really appreciated it and enjoyed watching the master at work.

Senator HARKIN. It was very interesting.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Madam Secretary, could you just elaborate on what is going to come out with regard to breast cancer, what you are expecting with regard to the Human Genome Project?

Secretary SHALALA. Yes—in the prevention package?

The CHAIRMAN. No; just in response to Senator Harkin.

Secretary SHALALA. The Human Genome Project—I think Senator Harkin may well want to comment, since he has talked to Dr. Collins, too.

The CHAIRMAN. Senator Harkin.

Senator HARKIN. Well, they are very close to finding the markers on certain genes that indicate a propensity toward breast cancer. I do not know that they are going to do it this year, but they are very close to it. We already have some preliminary information on that that I have spoken to him about, but they do not really have it quite tied down yet.

Again, we have part of it now to indicate some propensity, but he believes we will probably have the entire gene mapped by the end of 1995, early 1996. They are working on certain portions of it now—Huntington's disease, Parkinson's, and breast cancer is an-

other one—and we think that by 1996 or 1997, we will have it both mapped and sequenced so that we will have a definitive marker for a propensity to breast cancer. What will come out shortly this year or early next year will be some of the first markers on that. It will not be comprehensive, but it will be some of the first markers.

Secretary SHALALA. The implications of it, Mr. Chairman, are that if we can fine-tune our ability to identify those women who are more likely to have breast cancer, we can focus our resources, mammograms, and more careful screening on that group of women. This is an example of where an investment in basic research—the creation of the Human Genome Project—and I am sure when Dr. Varmus comes up for his confirmation hearings, he will be talking about the range of new scientific discoveries that are going to be possible because of this committee's commitment and investment.

The CHAIRMAN. Thank you very much.

Senator Mikulski.

OPENING STATEMENT OF SENATOR MIKULSKI

Senator MIKULSKI. Thank you very much, Mr. Chairman.

Dr. Shalala, we are really very impressed with the fact that the President has undertaken to give us a benefit package that focuses on prevention, primary care, and personal responsibility.

I think what you are hearing, though, in today's hearing is that we are now in a postrhetoric phase. We have had the launch strategy, we have had the momentum strategy in terms of what has come out of the White House, and it has been stunning. But what we are into now is really the specificity of the plan and the direction we need to go in, and I think this is the nature of the questions that you are getting.

Mine goes to a preventive aspect particularly related to women's health care, and we appreciate the fact that the President has really taken women and their needs seriously. As you know, the preventive aspects that are talked about in the plan, particularly the diagnostic screening or the screening, are far more skimpy than is recommended by professional associations, whether it is the American Cancer Society, the American Society for Ob-Gyn, in terms of when and how often pap smears and mammograms are being done.

Could you elaborate on whether this is open for discussion; was this decision based solely on the issue of cost, and how do we proceed with this—because I am getting calls that say hats off for including this in the first place, but is this good enough to really function, or is this a hollow victory.

Secretary SHALALA. All of the decisions about the prevention package were made on the basis of the latest scientific information, and there has been a recent panel the information for which is starting to come out on the issue of breast cancer and how often women need mammograms.

Whether the National Cancer Society will agree with those findings or not, or as the American College of Physicians and the other medical groups review them, we believe those scientific findings will hold up. But based on those scientific findings we have modified, as I reported earlier, Senator Mikulski, the diagnostic screening for breast cancer related to mammograms and to breast examinations and added the high-risk group, the definition of which will

be determined by the national board, for the diagnostic screening, with mammograms as often as they are needed.

So in addition to the mammograms for women over 50 which reflect the scientific evidence to date, we are adding the high-risk group for regular mammograms with no copayment.

Senator MIKULSKI. Dr. Shalala, are you saying therefore that the "how oftens" and at what age groups were determined not on the basis of cost, but on the basis of scientific findings?

Secretary SHALALA. I am, but in addition——

Senator MIKULSKI. Let me then say this. Obviously, these findings are under dispute, or these findings are not well-known and well-disseminated.

Secretary SHALALA. No.

Senator MIKULSKI. At the risk of sounding hubris here, I pride myself on knowing what is going on in terms of the diagnostic aspects related to women's health. We are all wearing these little pink ribbons for Breast Cancer Awareness Month. And I am not here to dispute the scientific findings, but I do not think these scientific findings have been widely promulgated. I think they are under dispute. And if in fact the benefits package is going to be determined on the basis of science and not cost, which would indeed be an ideal situation, then I think we need to promulgate that; or, if they are being made on the basis of cost, say that, and not call it scientific findings.

Secretary SHALALA. Senator Mikulski, they are being made on that basis; they are under review, though, and one of the reasons, since we are using the latest scientific panel findings, we need to explain what we are doing to make sure that we cover both the high-risk group as well as the group that has been identified for diagnostic screening according to the scientific findings in the diagnostic prevention package. But any woman who feels that she ought to get a mammogram will be able to go to her physician and get that mammogram. She may have a small copayment if she is not either in the high-risk group or in the group that has been identified on the basis of scientific research.

Let me say finally, Senator Mikulski, that I agree that because we are making these decisions now, and we are still in conversation with both the groups and with members of Congress, they are not finalized on this whole prevention package, but will be in the next 2 weeks. One of the reasons that you and I committed to science and to scientific findings are suspicious is because we basically are part of the generation, and led by many women and supportive men in Congress, who had to drag both the scientific establishment and the health community into focusing on women's health, and therefore there is an underlying suspicion by all of us—and that includes the Secretary of Health and Human Services. You can be assured that both Mrs. Clinton and I are going to personally look at the package of women's health services that go into this package, and we are going to be open and friendly and supportive and relaxed about any kind of discussion we have.

Senator MIKULSKI. Dr. Shalala, I appreciate that. I have been told I have 2 minutes, and I really have some other questions I want to get in. I know you have been supportive, and I agree with your statements.

My questions, though, go to what Senator Gregg talked about and also many of the questions raised by Senators Harkin and Dodd. We need to know what this is, and we cannot say we will drop you a line and explain that maybe you can get a mammogram if you need it and if it is medically necessary. There is a great deal of confusion about this plan. There is a great deal of confusion about what triggers what. There is a great deal of suspicion about the health alliances. You can say all you want about, well, if it is medically necessary and all of those wonderful things, but if you have solely market-driven health alliances, I am not sure how those decisions will be made, and a lot of us are not sure, and at the same time we are being very friendly.

So we are laying those issues out and hope to arrive at a core benefit package with diagnostic screening that does meet the test of science, and good science, without gender blinders on it.

But I want to go, if I can, just to one other issue, Mr.chairman, with your indulgence, as chairperson of the Subcommittee on Aging. While we are talking about this health insurance reform, you have within your shop the Older Americans Act, which I think, Dr. Shalala, is one of the core components in preventive services.

Senator Harkin talked about the children's nutrition program, the school lunch program. I would hope that as part of the preventive aspects, you would also look at those feeding programs available to the elderly, both the meals-on-wheels and the congregate services, in terms of what they need in terms of adequacy and the need for food and hydration.

Second—and this is really a heads-up unless you want to comment—as the chair of the Subcommittee on Aging, I have been very concerned about the uneven nature of something called "geriatric evaluation service" that are provided under the Older Americans Act. In one case, they relate to the Francis Scott Key program in Maryland, run by Johns Hopkins, that we used for my own father, that included a comprehensive physical, neurological and psychological evaluation. When he became ill, that is how we were led to the findings on Alzheimer's disease. But that is not replicated around the State of Maryland. Every county has its own geriatric evaluation, and in some places, it is just somebody with a book and a list of phone numbers. That is not adequate for geriatric evaluation services in the United States of America. It has to be comprehensive, it has to be clear, and it has to have definite uniform standards, because that will be in many ways the gateway to these community-based services that we are talking about.

So I really urge you and your excellent new assistant secretary for aging to really look at the geriatric evaluation services, because I think they leave a lot to be desired.

Secretary SHALALA. Thank you very much, Senator.

Just a quick comment. On your recommendation, I actually personally have been visiting a lot of the feeding centers, the nutrition centers, that serve our elderly population to take a look at them across the country myself, as we think through what are the appropriate programs and policies.

Second, I hope when we come in in a couple of weeks and lay out the plan and talk about its market elements, that you will begin to see it as I see it, and that is as a consumer-driven pro-

gram with consumer protections and the consumers really being in the driver's seat. If we have not quite gotten that right, I am sure that I will hear from you, but would also assure you that that is exactly the direction that we are moving in.

Senator MIKULSKI. Mr. Chairman, you have been generous with your time. Thank you.

The CHAIRMAN. Thank you very much.

Senator Wellstone.

Senator WELLSTONE. Thank you, Mr. Chairman.

First, Madam Secretary, I would like to commend you and Health and Human Services for your emphasis on preventive health care and for your emphasis on outreach into community and public health. I think it is extremely important, and I am very pleased that you are here today.

Let me pick up on a couple of things that have been said—that is the one advantage of waiting and being at the end. I think one of the things you have heard from a good number of us on the committee today is that it is important not to over-promise, and the first two questions people ask us in our States and in our communities is, a) will I be covered and will my loved ones be covered; and b) is it going to be a decent package of benefits. We cannot scale that back. That is the contract we have made with people. That is the promise that has been made to people.

Let me emphasize what Senator Simon mentioned earlier. I do believe that co-pays that are too high, especially on the low-income end, will undercut the very thing you are trying to do with preventive health care, and I think Senator Simon's concern was right on the mark.

Let me also emphasize that in your definition of preventive health care, I think we are going to have to do better on mental health, because 50 percent co-pays on outpatient care and some of what we have done with mental health I think will discourage the ways in which mental health can really be preventive health care, and I will give an example in a moment.

A three-part question. First of all, I would like to go to the question Senator Mikulski raised, and this is the thing that bothers me the most. I really appreciate where we are at right now in the country, and thank you for your leadership. But quite frankly, yesterday, in talking with the caregivers, I had articles from the Washington Post and the New York Times with titles like, "Merger Mania, Humana Moving into Managed Care," the whole danger of oligopoly, big insurance companies targeting these managed care networks. And I have to tell you, if they compete on the basis of keeping costs down, not only is it not clear to me whether we are going to have collusion as opposed to competition, but it is also not clear to me whether they have the incentives to actually provide good care to poor people, who are the most expensive people to deal with.

So the question becomes in terms of where they locate their services, whom they market to, whose phone calls they return, whether they are culturally sensitive, whether they even give a darn if the bottom line is the only line. People ask this of me, Senator Mikulski, in inner city communities, and they ask the same thing in small town rural areas.

So number one, where do poor people fit in. No. 2, I believe in the proposition, and I think my colleagues do, that whatever plan we are able to afford for ourselves and our children, that plan should be affordable and available to the people we represent. How do we avoid these tiers? You talked about choice—higher tier, average price plan, and low. Low-income people will be in the lower price plan. They do not really have a choice to go to the next level up or the next level up. How do we prevent stratification and tiers built into this whole delivery to the point where we are right back to where we do not want to go?

And then, finally, the last question I want to ask, which is so important, and I am hoping to get a strong, affirmative answer from you, and if you have specifics, great—where will the public health infrastructure, and the community health care clinic, and the family planning clinics, fit in, because they have done a great job of being out there in the community, of empowering people, where people are in fact able to have more control over the services and take more charge over their own lives. And frankly, these big alliances or networks, many of them run by insurance companies, are not going to do that. They are not going to do that.

Secretary SHALALA. Thank you, Senator. First, let me tell you that our bottom line is quality, access and quality. While the President's plan obviously would like to and intends to control costs, as I have said in other places, 30 years from now when this plan is reviewed by the people and by historians, it will be measured by whether it provided quality health care to every American, not whether it provided it to rich Americans as opposed to poor Americans. So I believe that the bottom line and the design of the plan begins with that core commitment.

Second, on the issue of the organization of the plan and how do we protect the underserved—but more importantly, empower the underserved—how does their situation get better, not simply because they get a health card, but because they get real access to quality health care—what happens to minority providers? Do they get invited in? Do they have a chance to participate in some of the larger plans? What if a group of doctors get together, and they do not belong to one of these big insurance conglomerates; are they protected in the system?

Those are precisely the kinds of things that we believe we have built into the plan, and as the legislation comes up here, we will have detailed discussions with you.

Let me speak specifically, though, to the group that we call essential providers, and that is the community health centers, the federally-sponsored health centers, the public hospitals, those that are currently serving low-income people and have done it after years of fine-tuning and working with great sensitivity. They will very much have a part in this new health plan.

We do not believe that simply giving every person in America a card means that they have real access, means that they can successfully access a system that does not have to change. Not only will those essential providers be protected in the system, because they will be rejuvenated with a public health piece that we intend to come in with, but we intend to mandate the alliances to contract

with them for the provision of services, and they will very much be a central part of this overall strategy.

So that you will see in the public health initiative that we bring in as part of the overall plan, as well as in the details of how the alliances are going to work themselves, a strong role. Now, many of those institutions will be in better shape because they actually will be serving people whom they will be reimbursed for. They can organize in some cases the public hospitals themselves into plans. We will come in and detail the kinds of strategies, but let me assure you we do not believe that we can simply walk away from either the poor or the working poor simply by giving them a card and some choices among health plans.

Senator WELLSTONE. I have run out of time, but just a quick response to your response. I do believe that community health care clinics should have access to capital and assistance so they can phone their own networks, so they do not have to work for one of these large managed care plans, which, I am telling you, the trend right now is more and more concentration. So I do not think they necessarily will want to have to work for a plan run by Signa or Prudential or whatever, number one. I think they should be able to do that.

The second thing is I think we are going to want to see exactly what expansion of resources is going to be going into this infrastructure of delivery.

My final point is, in all due respect, I do think we have a problem of incentives. I think if you have these plans competing on the basis of cost, there are all sorts of reasons why they may not want to include a lot of poor people—and then we are going to have to regulate the very disincentives or distorted incentives and create a bureaucracy that we do not want to create. I think there is a problem here, and I will leave it at that right now, but we can continue to talk about it.

Secretary SHALALA. We look forward to working with you, Senator Wellstone. I hope that you will see the incentives in terms of our ability to work with these community-based programs and the public hospitals to help them create networks. We did do some thinking in this area, but we certainly look forward to both the conversations and whatever changes or reorganizations you may suggest.

Senator WELLSTONE. Thank you very much. I was going to talk about an anger management program, which I think would be very relevant to all of us, in the mental health field, but I think I will just put that question to you later.

Secretary SHALALA. OK, great.

The CHAIRMAN. I would just underscore Senator Wellstone's point about the community health programs. There is a lot of concern that with the emphasis on primary care, they have taken a long time to finally get their doctors, and they may be pulled away. And you have a lot of them who do receive—in my State, about half of them receive Federal funds; others do not. We want to make sure that the complex issues involving those community health services are included in the plan.

Secretary SHALALA. And we are actually in conversation with your staffs about the community health centers and about these initiatives.

The CHAIRMAN. Thank you.

Senator Wofford.

Senator WOFFORD. Mr. Chairman, despite the fact I am at the end of the line, I have no anger in me to be managed, no frustration. I am in fact encouraged tremendously by the fact that, one after another, the questions I wanted to ask and points I wanted to make sure were addressed have been pressed by my colleagues, and it encourages me to believe that, together, we are going to get at this. We are going to see it, look at it from all angles, and we are going to succeed in a plan that makes sense.

I am also encouraged by Secretary Shalala's candid responses today, and in Pennsylvania, when she was good enough to spend the day and night up there with us, answering all kinds of questions. And I spend a good part of the night with her last night, listening to her—on C-SPAN——

Secretary SHALALA. I am glad you clarified that, Senator. [Laughter.]

Senator WOFFORD. I look forward to more evenings like that. It is my addiction, this subject.

So I will just ask two questions now. I was glad to see that the President's plan includes new funding for NIH for prevention research related to both the biomedical and behavioral aspects of health promotion and prevention. I am interested in what in particular is planned in the area of nutritional research. I know the National Cancer Institute has studied the relationship between diet and cancer, and there was a very interesting report yesterday on the link between prostate cancer and dietary fat. Are other such efforts planned, and what efforts will be made to disseminate this information to the public on a regular basis so individuals can act and adapt their lifestyles?

Secretary SHALALA. Senator, this country has not made a commitment to nutritional research of any substantial amount in many years, almost a generation. As we move into a different attitude and a different investment in prevention, nutrition research becomes terribly important. So that it is not only the National Institutes of Health in terms of the kind of primary research they will be doing, but behavioral research on nutrition. To make Americans healthier, we need to know a lot more about what people eat and in what quantities and the range of nutritional issues so that that information can be passed on not only to the individuals, because part of this new health care strategy is individual responsibility, but also to health care providers and to companies that provide meals to the people at the Agriculture Department who work with the school lunch program. I mean, there is a range of issues in which we need to take a big step up in terms of investment and dissemination strategy to have an impact on people's behavior and on the behavior of our institutions.

Senator WOFFORD. You and everyone else in this field have discovered that another really encouraging thing is the degree to which this whole range of preventive action is a common ground between Republicans and Democrats, the administration and Con-

gress and the people in the field on the front lines from whom we are going to hear. So I just want to enthusiastically join in that emphasis, to hammer further that point here and with the American people.

One area is violence and the connection between violence and prevention of health costs. I was pleased with the appointment of Dr. Satcher from Meharry Medical College as director of the Centers for Disease Control. I know he is especially interested in increasing efforts in violence prevention. Do you have any existing or future plans for initiatives in this area that you would like to talk about today?

Secretary SHALALA. We do, Senator. Attorney General Reno and I have put together a task force chaired by two of our senior colleagues. In my case, Peter Edelman is chairing it for HHS. They are focusing initially on youth violence and on domestic violence, and we expect them to report back to us initially by the end of the year because the Attorney General and I are very anxious—this will be a Government-wide task force that they are heading—we are very anxious to give the President some recommendations that can have an impact on not only how our agencies behave, but strategies that will really make a difference in working with communities.

We see violence as a public health issue, with a clear public health dimension, and believe that there are many things that can be done in our communities that would mitigate against violence, not the least of which is to do something about the terrible proliferation of guns in our communities and the kind of hopelessness in our communities. It requires an integrated strategy, and by merging for the first time the Department of Health and Human Services and the Attorney General's Office, we are getting a clearer dimension to what we might do together.

Senator WOFFORD. Well, let us do it, because as Dr. Satcher said, if violence is not a public health problem, why are all these people dying from it.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Wofford.

Madam Secretary, other of our colleagues are here, but we have a situation where we do have a vote. So I am going to leave the record open for additional questions, and what I would like to do is recess briefly and then hear our next panel. It is a very impressive panel, and we want to hear their testimony. So if that is agreeable with the members, that is the way we will proceed.

Senator GREGG. Mr. Chairman, is it possible that the Secretary, after we get these numbers and the backup information, will be able to come back to the committee?

The CHAIRMAN. Oh, yes.

Secretary SHALALA. Yes, certainly.

The CHAIRMAN. She has said she would be delighted to do that.

Secretary SHALALA. You will see me and everyone else in my Department, Senator.

Senator GREGG. Thank you.

The CHAIRMAN. Thank you.

We thank you very, very much for your testimony. It has been enormously helpful and impressive, and it is obviously an area that

this committee is very interested in. We are grateful to you for your presence.

Secretary SHALALA. Thank you, Mr. Chairman.

The CHAIRMAN. Before we introduce our next panel I have statements from Senators Wofford and Hatch.

PREPARED STATEMENT OF SENATOR HATCH

Mr. Chairman: I am pleased that the committee is holding this hearing today. And, I am even more pleased that Secretary Shalala has chosen the theme of prevention for her first health care reform testimony before the Committee.

Welcome to the Committee, Madame Secretary. It is always good to see you.

If your staff has done its job, you know that traditionally three issues are certain to get Orrin Hatch's immediate attention: AIDS; home health; and prevention. Today, I'm going to have to amend that list to add dietary supplements and medical devices, and I hope these are issues we may talk about at another more appropriate time!

As you know, I have long been a champion of preventive health initiatives. I am glad that the Administration recognizes they must be a part of any serious health care reform package. If we had been more successful in promoting prevention over the past decades, we wouldn't have some of the health problems we face today!

In a July 22, New England Journal of Medicine article, Stanford University Doctor James Fried noted that "Preventable illness makes up approximately 70% of the burden of illness and the associated costs." He showed that health habits have a strong correlation with health insurance claims costs. In one study Dr. Fried cited, persons at low-risk had average claims of $190, whereas those at high risk at claims averaging $1,550.

The implications of these statistics for health care reform are staggering.

Madame Secretary, in your testimony yesterday on the House side you said something that got my attention. You reminded committee members that "an ounce of prevention is worth a pound of cure," and you added that "until now we have been a country that is all too ready to spend a pound while conserving our ounces."

There is a lot of merit in what you said. But, while it may be true in the sense of overall health care spending, I can't help but remember some of those battles we've had over on the Finance Committee. Every time we tried to authorize any new spending for prevention activities, we were told it couldn't be done because it would "score" and we did not have "offsets"!

So, I see this year's debate as an improvement over our previous narrow-sighted, budget-blinders approach. The Administration's heightened dialogue on health care reform offers the country the real opportunity to shift our focus away from short-term struggles to long-term successes in the area of prevention. I happen to believe that these long-term successes will result in substantial cost-saving as well as life-saving.

So, I will reiterate what I have said to Mrs. Clinton in our meetings. I want to work with you and Senator Kennedy and Senator Kassebaum as this process unfolds. There is no issue more impor-

tant than health care, and no health care issue more important than prevention.

[The response to questions for Secretary Shalala from Senator Hatch may be found in the files of the committee.]

PREPARED STATEMENT OF SENATOR WOFFORD

Welcome to our distinguished witnesses. Today we will be talking about one of the key building blocks of national health care reform—prevention. Preventive care and prevention services will not only help control spiralling health care costs, but also improve the lives and health of our nation's families.

The economic costs of the lack of preventive care in our nation are astounding. The lifetime cost of treating a child with congenital rubella can be as high as $400,000, yet could have been prevented if the mother had been immunized for $30. Care for the tiny, low-birthweight babies whom Bill Clinton and I visited last year at Pennsylvania Hospital's neo-natal intensive care unit ran into hundreds of thousands of dollars each. But if their mothers had received a few hundred dollars of prenatal care, many of those babies could have been born healthy. I've seen cases like this all over Pennsylvania and indeed they exist all across the country.

Of the over $900 billion we spend a year on health care, less than three percent is spent on preventive services, and a large percentage of the rest of these costs could be avoided through appropriate preventive care. It's time that we make preventive care—taking the measures to keep people from getting sick and keeping them well—a top priority.

More importantly, the human cost of this lack of preventive care is devastating. Our country's infant mortality rate is higher than in most other industrialized countries, and for nonwhite babies the statistics only get worse. Throughout the nation, there is a shocking rate of preventable illness, including hypertension, lead poisoning, AIDS and other infectious diseases, particularly among inner-city populations.

Including preventive services in the basic benefits package is a necessary first step, but we also must ensure that all Americans have real access to these services. We can do this by investing in our public health delivery system—a major vehicle of preventive care—and by increasing our investments in primary care health professionals. Right now only 30 percent of our nation's doctors are primary care physicians and 70 percent are high-priced specialists. We need to focus our resources, and encourage young medical students to go into primary care. Because through these investments, we can demonstrate a commitment to caring, not just curing.

We also need to encourage people to change unhealthy behavior—the kind of behavior that is contributing to escalating human and economic costs.

Violence, especially in our inner-cities, has become a public health crises. It has reached truly epidemic proportions—affecting even toddlers, as tragically demonstrated this past week in the District of Columbia. Dr. Satcher, the new head of the Centers for Disease Control, has said, "If violence is not a public health problem, why are all those people dying from it?" Violence is a leading cause of injury and death and we must work to stop it.

The links between our behavior and our health are obvious. People have to recognize and take responsibility for the costs of smoking, excessive drinking, and lack of exercise. One of the key elements of the reform the President and I both want to see is responsibility. We all have to take greater responsibility for our own health, and that of our children, to make health care reform a success. It was one of the key points Secretary Shalala and I stressed in a visit to Harrisburg this past Friday. And it was the focus of a hearing I held earlier this year at Temple University.

To Secretary Shalala and our other witnesses: I look forward to working together to make sure that the prevention cornerstone is a key part of our new health care system.

The CHAIRMAN. As soon as we return, we will hear from representatives of different organizations about prevention programs. Florence Griffith Joyner is here from the President's Council on Physical Fitness, the task force that was created to promote healthy lifestyles and encourage individuals to seek preventive services generally.

Dr. Irvin Fleming is president-elect of the American Cancer Society. Dr. Charles Francis is a member of the board of directors of the American Heart Association. Dr. John Ludden, from my home State, represents the Harvard Community Health Plan. And finally, Dr. Douglas Henley, with the American Academy of Family Physicians.

If you would be good enough to come forward, we will recess briefly and then resume to hear your testimony.

[Recess.]

The CHAIRMAN. The committee will come to order.

We apologize to our witnesses for the interruption and for their patience here this morning. The testimony you will give is enormously important, and we are particularly honored to have Florence Griffith Joyner with us today. I think all Americans have been inspired by her extraordinary grace and sportsmanship and talent as well as the honor she has brought to this country in athletics as well as respect for her personally and her strong and continuing commitment to all Americans in the area of physical fitness and sports.

We are delighted to have you here and look forward to hearing your testimony. And if you would like to introduce your husband, we would be glad to welcome him as well.

STATEMENTS OF FLORENCE GRIFFITH JOYNER, CO-CHAIR, PRESIDENT'S COUNCIL ON PHYSICAL FITNESS AND SPORTS, WASHINGTON, DC; DR. IRVIN D. FLEMING, PRESIDENT-ELECT, AMERICAN CANCER SOCIETY, WASHINGTON, DC; DR. CHARLES K. FRANCIS, CHAIRMAN, DEPARTMENT OF MEDICINE, HARLEM HOSPITAL, NEW YORK, NY, AND MEMBER OF THE BOARD OF DIRECTORS, AMERICAN HEART ASSOCIATION, WASHINGTON, DC; DR. JOHN M. LUDDEN, MEDICAL DIRECTOR, HARVARD COMMUNITY HEALTH PLAN, BOSTON, MA; AND DR. DOUGLAS E. HENLEY, MEMBER OF THE BOARD OF DIRECTORS, AMERICAN ACADEMY OF FAMILY PHYSICIANS, KANSAS CITY, MO, AND CHAIRMAN, ACADEMY COMMISSION ON PUBLIC HEALTH AND SCIENTIFIC AFFAIRS

Ms. JOYNER. Thank you very much, yes. Al Joyner, Olympic gold medalist from 1984, and he is also training for the Atlanta Games in 1996.

The CHAIRMAN. Good to see you. Thank you.

We would be delighted to hear from you now.

Ms. JOYNER. Thank you, Mr. Chairman.

It is a distinct pleasure and honor to testify before this committee. When I talked to the President and then read his health care reform plan, it was heartening to see that prevention is finally being recognized as a major and critical factor in the health care arena.

I am sure all of us agree with the common sense wisdom that President Clinton referred to in his address to the Congress, when he reminded us that, "All our mothers told us that an ounce of prevention is worth a pound of cure."

But as a Nation, we do not abide by that lesson, and that is why the obvious, common sense preventive measures which comprise the President's plan will reap great benefits to individual health and to the Nation's economic health.

The President's proposal includes a whole range of achievable preventive measures, from regular checkups to a comprehensive immunization approach, to emphasizing the need for regular exercise activity for all.

All of the preventive prescriptions proposed in the health care reform plan echo our mothers' mandate to take that "ounce of prevention," which we must do to ensure that our national family will not be faced with having to ensure and pay for the inevitable and expensive "pound of cure."

If prevention is the most effective approach in reducing the need for medical services, then physical fitness and exercise is the keystone of the prevention arch. If we had a country that was more fit, we would need far fewer medical services; we would substantially reduce the adverse economic impact of those services; we would raise the overall quality of life and have a far more productive work force.

Despite the increasing evidence of the health benefits of physical activity, the United States remains a predominantly sedentary society. Despite the well-known fact that individuals who engage in no physical activity are at a higher risk of death from coronary heart disease, it has been documented that nearly 60 percent of the

United States adult population reported little or no leisure time physical activity.

This fact was highlighted last year when physical inactivity was cited by the American Heart Association as joining high blood pressure, smoking, and elevated cholesterol levels as the leading causes of heart disease.

The fitness of our youth is in an equally disturbing position. Youth fitness has not only not improved over the last 10 years, but in some cases has actually declined. Not only have children become fatter since 1960, but 40 percent of children ages 5 through 8 show at least one heart disease risk factor—being physical inactivity, obesity, elevated cholesterol, and high blood pressure.

Mr. Chairman, the American body politic is overweight, out of shape, out of breath, and inactive to the extreme. If America is to truly get serious about health care reform, then it must also get serious about reforming its exercise and physical activity habits.

Without simple but effective exercise and physical activity habits, even the most ambitious and enlightened health care reform program will be handicapped from the start.

When I accepted this position with Tom McMillen as co-chair of the President's Council on Physical Fitness and Sports, President Clinton stated that he wanted us to emphasize fitness for all. We recognize that our message must be targeted to different segments of our population. We want to target seniors as well as young people. We recognize the needs of special populations like inner city residents and Native Americans. We understand the level of violence that permeates our society and the value of exercise and sports in reducing tension and stress.

If we are to be successful in preaching the value and benefit of exercise and fitness, it is critical that exercise and fitness be recognized as everyone's responsibility to himself. As President Clinton said in his speech on health care reform, "Too many of us have not taken responsibility for our own health care."

I was born and raised in Watts, the seventh of 11 children. My mother instilled in her children the values of independence and individualism. She stressed the need to perform as best you can and served as my role model and inspiration.

While I have been most fortunate in my athletic career and endeavors, I consider my appointment as co-chair to be my greatest honor as it allows me the opportunity to communicate the value of exercise and fitness with so many others. At the Council, we envision major cooperative efforts with business, industry, educational institutions, and nonprofit and grassroots organizations, to highlight the need for all Americans to be physically fit. We value the benefits of organized team sports and will call on amateur and professional athletes to serve as role models.

Mr. Chairman, we will also need the help of your committee, the Cabinet, members of Congress, governors, mayors, and locally-elected officials to make the fitness of America a high priority.

We want to emphasize family fitness. Parents must recognize that they serve as the primary role models for their children and should be encouraged to exercise and by physically active with their children to set the right example.

We need to instill in our children the fact that exercise should be a lifetime habit. Fitness is not something that one achieves and then moves on to something else. Just as we need to instill in our children sound eating habits, they must also realize that to live as full a life as possible, they must exercise and be physically active for life.

We must reach out to the adult population to make them realize that they can be in control of their own health and that exercise is critical to improving their quality of life. There is a critical need to substantially change this country's mind set regarding sports, physical activity, recreation and fitness from that of a spectator to that of a participant.

Mr. Chairman, I thank you for allowing me to appear before this committee, and I will be pleased to answer any questions you may have.

The CHAIRMAN. Thank you very much.

Dr. Fleming, please.

Dr. FLEMING. Mr. Chairman, it is a real pleasure to be here this afternoon representing the American Cancer Society. The release of President Clinton's comprehensive health reform proposal has launched a public debate that has been in the making for decades, and the American Cancer Society applauds President Clinton and First Lady Hillary Rodham Clinton for recognizing that there is no more time for delay.

I am also here to thank the members of the Senate, both sides of the aisle, for the leadership many of you have shown on this issue. I implore you to seize the moment and find a nonpartisan solution to the health care crisis confronting America. We cannot afford to wait any longer.

In 1989, the American Cancer Society renewed its commitment to address health care reform for all Americans, particularly those who are socioeconomically disadvantaged, and developed a statement of principles which summarized the cancer control needs of the Nation. My comments this afternoon relate primarily to President Clinton's plan, but we will be in the next few weeks analyzing the other major congressional proposals according to these principles.

President Clinton's strong position on prevention and health promotion is vital to improving the health of our Nation's citizens, and the ultimate legislation that is enacted must include this important component.

An emphasis on prevention reduces human suffering and saves millions of dollars in the treatment of avoidable diseases. President Clinton's plan provides routine preventive health exams that will offer appropriate risk avoidance and health education for all Americans, including nutrition counseling, skin cancer prevention, and smoking cessation.

I must emphasize that smoking kills 419,000 Americans each year, yet accounts for one-third of all cancer deaths and robs our economy of more than $68 billion in needless health care costs and lost productivity. Tragically, 3,000 teenagers become regular smokers each day in the United States. Any plan adopted must include a strong educational component for children and adults about the dangers of tobacco.

Research is showing the important role nutrition plays in preventing and reducing certain cancer risks. The American Cancer Society has incorporated into its prevention strategy the promotion of comprehensive school health education in order to educate individuals from youth about risky behavior such as smoking and tobacco use. Statistics reveal that among all age groups, just three diseases—cancer, heart disease and stroke—account for nearly 70 percent of all deaths. In many cases, these conditions are preventable and are substantially due to behaviors established during youth.

A well-coordinated education program for grades kindergarten through 12 will provide young people with the knowledge, skills and attitudes needed to control and limit behaviors that place them at risk.

The ability to detect and diagnose cancer in an early stage, while not prevention, is critical to preventing suffering and savings lives from cancer. We are pleased to see that President Clinton's plan acknowledges the lifesaving benefit of pap smears, pelvic examinations, and mammography. The coverage of pap tests and pelvic exams conforms to the American Cancer Society's recommendations for asymptomatic women.

With regard to screening mammography, the plan proposes full coverage every 2 years for asymptomatic women age 50 and older. However, according to Mrs. Clinton, every woman may be able to have a mammogram or pap smear on the advice of her physician if she is at risk for breast or cervical cancer or has symptoms of these diseases.

The American Cancer Society acknowledges this attempt to ensure access for all women for whom these tests are appropriate. However, we have some concerns about how reimbursement is structured for asymptomatic versus at-risk individuals.

The American Cancer Society believes that a diagnosis of breast cancer in an early stage provides a woman more choices in terms of treatment and may substantially reduce her suffering. Until such time that we have better information on prevention of breast cancer or improved detection tests, we recommend screening by the current American Society guidelines.

The American Cancer Society supports a $2 per pack increase in the cigarette excise tax which is supported by the majority of the American public. A major tax increase would simultaneously help pay for health care reform, offset the enormous burden of tobacco-related diseases and, more importantly, discourage millions of young people from beginning to smoke in the first place.

In closing, Mr. Chairman, it is time to recognize the need for sound, effective preventive medicine as a routine part of health care for every American. The American Cancer Society will work with the Clinton administration and Congress on the final resolution of specific plan elements as they relate to the needs of millions of Americans living with cancer and every American who may potentially be at risk for cancer.

Thank you for the privilege of being here.

The CHAIRMAN. Thank you very much.

[The prepared statement of Dr. Fleming follows:]

PREPARED STATEMENT OF DR. IRVIN D. FLEMING

Mr. Chairman and Members of the Committee, it is a privilege to be here this morning. The release of President Clinton's comprehensive health care reform proposal has launched a public debate that's been in the making for decades, and the American Cancer Society applauds President Clinton and First Lady Hillary Rodham Clinton for recognizing that there is no more time for delay.

I am also here to thank you, Members of the Senate from both sides of the aisle, for the leadership many of you have shown for years on this issue. I implore you: seize this moment and find a nonpartisan solution to the health care crisis confronting America. We cannot afford to wait any longer.

In 1989, the American Cancer Society renewed its commitment to address health care reform for all Americans, particularly those who are socioeconomically disadvantaged, when we conducted hearings around the country to find out how poor Americans fare when they are diagnosed with cancer. We learned that deaths from cancer are higher among groups that lack knowledge about how to prevent or control cancer and among those without access to the health care system. To address these issues, the American Cancer Society developed a Statement of Principles on Health Care Reform which summarize the cancer control needs of this nation. My comments this morning relate primarily to the Clinton plan, but we will analyze each proposal according to our Principles.

President Clinton's strong position on prevention and health promotion is vital to improving the health of our nation's citizens. We will work to ensure that all proposals coming from Congress, and the ultimate legislation that is enacted, will acknowledge and include this important component.

Cancer prevention demands education and regular medical care to empower individuals with the information and medical tests to help reduce their cancer risks. An emphasis on prevention reduces human suffering and saves millions of dollars in the treatment of avoidable disease. We are pleased that the Clinton plan provides routine, preventive health exams that will offer appropriate risk-avoidance and health education for all Americans, including nutrition counseling, skin cancer prevention, and smoking cessation.

On that note, I must emphasize that smoking kills 419,000 Americans each year. It accounts for about 30% of all cancer deaths, and it robs our economy of more than $68 billion in needless health care costs and lost productivity. Tragically, approximately 3,000 teenagers become regular smokers each day in the United States. Any plan adopted must include a strong educational component for children and adults about the dangers of tobacco use.

Research is showing the important role nutrition plays in preventing cancer. For example, individuals who are 40% or more overweight increase their risk of colon, breast, prostate, gallbladder, ovary, and uterus cancers. Studies have likewise shown that daily consumption of vegetables and fresh fruits is associated with a decreased risk of lung, prostate, bladder, esophagus, colorectal, and stomach cancer.

As mentioned above, cancer prevention demands an educated population—educated from childhood to avoid such risky behaviors as smoking and poor eating habits. In light of this, the American Cancer Society has incorporated into its prevention strategy the promotion of comprehensive school health education. Statistics reveal that among all age groups, just three diseases—cancer, heart disease, and stroke—account for nearly 70% of all deaths. In many cases, these conditions are preventable, and are substantially due to behaviors established during youth, are interrelated, and persist into adulthood. These conditions are substantially due to the use of tobacco, excessive consumption of dietary fat and calories, and a lack of physical activity. A well-coordinated health education program for grades K-12 would provide young people with the knowledge, skills, and attitudes needed to control and limit behaviors that place them at risk for preventable illness or death.

Another extremely important focus of the Clinton plan and other Congressional bills, is the focus on early detection of cancer. The ability to detect and diagnose cancer in an early stage, while not prevention, is critical to preventing suffering and saving lives from cancer. The American Cancer Society estimates that we could save 100,000 more lives this year alone from cancers of the breast, tongue, mouth, colon, rectum, cervix, prostate, testes and melanoma if these cancers had been detected in a localized stage and treated promptly.

We are pleased to see that the Clinton plan acknowledges the life-saving benefit of some of the cancer detection tests that the American Cancer Society has recommended. The White House proposal would cover Pap smears and pelvic exams that follow the American Cancer Society's guidelines for asymptomatic women. With regard to screening mammograms, the plan proposes full coverage every two years for asymptomatic women 50 and older. However, according to Mrs. Clinton, in addi-

tion to routine coverage under the "Preventive Services" section, however, every woman will be able to have a mammogram or Pap smear on the advice of her physician, if she is at risk for breast or cervical cancer, or has symptoms of disease. The American Cancer Society acknowledges this attempt to ensure access for all women for whom these tests are appropriate. However, we are concerned that the tests for at-risk individuals are provided as "diagnostic" exams when they are intended as routine screening tests. This may rely too heavily on health professionals to discuss risk factors and recommend detection tests to women who may benefit from the exam. Unfortunately, one of the primary reasons that women currently do not get mammograms is that doctors do not recommend the exam.

Finally, every woman is at risk for breast cancer, and that risk increases with age; will this complicate procedures unnecessarily by paying in full for an exam one year but not in other years if it is appropriate? Although the scientific debate on the mortality benefit from screening younger women for breast cancer is still going on, and screening intervals for women ages 50 to 70 needs further study, the American Cancer Society believes that a diagnosis of breast cancer in an early stage provides a woman with more choice in terms of treatment and may substantially reduce her suffering, a benefit that may be lost in the published results of clinical trial data. This is an important question when looking at breast cancer incidence and mortality rates among minority groups, for whom lack of access to screening and treatment has most often resulted in a death sentence. The American Cancer Society believes that a careful review of clinical evidence and scientific data, as well as health economics considerations, support a continuation of our current guidelines for breast and cervical cancer detection until such time as we have more information about mammography and other detection tests, or have learned how to prevent the diseases.

With the exception of mammograms and Pap smears, other cancer-screening tests and clinical examinations recommended by the American Cancer Society are not specifically mentioned in the plan as proposed. The American Cancer Society's cancer screening guidelines are intended to be used to guide individuals in making decisions about their routine health care needs. We will work with Congress to clarify these issues as we move forward in finalizing a standard benefits package.

Finally, the American Cancer Society's expertise is in the area of cancer, and not in health care financing. However, we believe that in order to ensure universal access to health care coverage and to focus most effectively on important aspects such as cancer prevention, effective cost-containment strategies must be implemented to control excessive costs. The financing of universal care ought to come from both the public and private sectors to avoid disproportionate burdens on any individuals or groups. We applaud the President's decision to require everyone in America to share the responsibility for ensuring health care for all Americans.

The American Cancer Society also supports, and calls on President Clinton to include, a $2.00 per pack increase in the cigarette excise tax. This method of financing has been proposed by the American Cancer Society and others, and is supported by 66% of the American public. A major tobacco tax increase would simultaneously help pay for health care reform, offset the enormous burden tobacco imposes on our economy and, most importantly, discourage millions of young people from beginning to smoke in the first place.

In closing, Mr. Chairman, it is time to recognize the need for sound, effective, preventive medicine as a routine part of health care for every American. We must build in mechanisms for reimbursing prevention, effectively transfer the scientific knowledge available to practitioners throughout the health care system, stop the needless loss of life, and decrease the wastefulness in not addressing disease before it has taken hold. The American Cancer Society will work with the Clinton Administration and the Congress on the final resolution of the specific plan elements as they relate to the needs of the millions of Americans living with cancer, and every American who may potentially be at risk for cancer.

Thank you for the opportunity to testify. I have provided, with my written statement, a copy of the American Cancer Society's Statement of Principles on Health Care System Reform and a copy of health care reform principles developed by the voluntary health agencies of the National Health Council, together representing 150 million Americans and their families living with disease, disability or other health disorder.

AMERICAN CANCER SOCIETY

STATEMENT OF PRINCIPLES FOR HEALTH CARE SYSTEM REFORM

Background

The American Cancer Society (ACS) is the nationwide, community-based, voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives from cancer and diminishing suffering from cancer through research, education and service.

Despite major advances in cancer prevention and control, millions of poor and underserved Americans are dying needlessly because they lack access to those services because of serious gaps in the current health care system. An estimated 37 million Americans are uninsured, and an additional 60 millions are thought to have inadequate health insurance coverage. This group includes many cancer patients who are "uninsurable" due to their diagnosis of cancer. Today, with the United States facing an uncertain economic situation, spiraling health care costs and health care cost-shifting have combined to widen the access gap already felt by millions. Every year, one million Americans will lose their health insurance because they lose their jobs or develop a serious illness. This will further inflate the number of individuals and families made vulnerable to cancer and other diseases.

In 1989, the American Cancer Society conducted a series of hearings around the nation to speak directly to socioeconomically disadvantaged persons of all racial, ethnic and cultural backgrounds to learn about the problems they face in obtaining health care. We also spoke to persons in these communities, including community, religious and business leaders, social workers and community health professionals, who understand the culture of poverty and how that impacts the health of poor and underserved Americans. We learned about obstacles to care: lack of knowledge about how to prevent or control cancer, and real and perceived barriers in the current health care system. At the conclusion of these hearings, our major findings were summarized in A Report to the Nation: Cancer and the Poor. They include the following truths.

Poor people lack access to quality health care and are more likely than others to die of cancer.

Poor people endure greater pain and suffering from cancer than other Americans.

Poor people face substantial obstacles in obtaining and using health insurance and often don't seek needed care if they can't pay for it.

Poor people and their families must make extraordinary personal sacrifices to obtain and pay for health care.

Cancer education and outreach efforts are insensitive and irrelevant to many poor people.

Fatalism about cancer prevails among the poor and prevents them from gaining quality health care.

The American Cancer Society believes that a health care delivery system should work in a way that makes it easy for people to obtain necessary care. Individuals should be empowered with the necessary information and tools to share responsibility for their own health care. As a nation, we must turn our attention to these serious unmet health care needs. The American Cancer Society believes that all Americans should have unimpeded and facilitated access to comprehensive quality health care services. This care includes cancer prevention and regular proper medical treatment and continuing medical care. It is the role of the American Cancer Society to focus the attention of policy makers at all levels of government on this problem, and participate in the debate by providing important information about the cancer control needs of poor and underserved Americans which can be incorporated into proposals for health care system expansion, reform or restructure.

The American Cancer Society believes that the United States is capable of delivering high quality, state of the art medical care to every citizen in the United States. The Society also believes that this point is well demonstrated by many components of our current health care delivery system which benefit a large segment of the population. The Society recognizes, however, that serious gaps exist in accessibility, affordability, and quality of health care for many Americans which must be addressed now by the nation as a whole. Health care reform in the United States must deal collectively with the complex and interrelated concepts of access, cost and quality in health care. To sacrifice one concept for another simply postpones the debate and the ability to implement necessary comprehensive reforms.

Thus, the American Cancer Society believes that a balanced approach to health care reform, encompassing elements of patient accessibility and nondiscrimination,

affordability and availability of care, standardization of covered services, insurance market reform, system administration reform, health care cost containment, provisions for quality assurance, technology assessment and practice guidelines, and education of the public and health care professionals, will best achieve its goals with respect to the delivery of cancer prevention and control services in the United States.

Eligibility

All persons have the right to health care, regardless of employment status, ability to pay, or preexisting health conditions.

Coverage and benefits

The U.S. health care system must provide for continuity and portability of health insurance benefits to ensure universal access.

Coverage should address the continuum of care and include cancer prevention, early detection, diagnosis, treatment, rehabilitation, and long-term care. More specifically, covered services should include, but not be limited to:

Cancer Prevention: regular, routine medical care to identify and reduce risks for cancer from environmental and occupational exposures; information about lifestyle choices, including diet and nutrition, and use of tobacco and alcohol; and limiting exposure to sunlight.

Cancer Early Detection: appropriate, effective cancer early detection tests for asymptomatic persons, according to guidelines of the American Cancer Society, the National Cancer Institute and other appropriate medical experts; and targeted assessments for individuals and family members at high risk for cancer.

Cancer Diagnosis and Treatment: medically-appropriate tests for the diagnosis of cancer; treatment for cancer which includes all medically-appropriate prescription drugs, therapies or modalities, including those prescribed for pain management; clinical trials of experimental protocols; and related services.

Cancer Rehabilitation: a range of services, including physical therapy, prostheses and medical devices, psychosocial counseling, occupational therapy, and all related services.

Long-Term Care: chronic, rehabilitative, home-based, nursing home, and respite care services to enhance the quality of life of cancer patients and their families. Emphasis should be placed on patient autonomy and responsibility. Avoid pauperization of the cancer patient and his or her family.

Delivery of Health Care Services

Encourage patient choice, autonomy and responsibility for the cost and use of health care services through continued educational and other appropriate strategies.

Medical benefits should be provided in a variety of health care settings.

Health care delivery systems should be organized to reduce fragmentation of available community services.

Health care reform proposals should ensure continued and expanded support of the U.S. Public Health Service and the community-based health infrastructure for the delivery of necessary health/cancer care services.

Simplification of the system

All persons should have unimpeded and facilitated access to the health care system.

Administration of the U.S. health care delivery system should be simplified to reduce costs and maximize resources for actual health care services. Standardize billing, claims, and utilization review procedures to significantly reduce the administrative costs of health care delivery, to ensure uniformity in coverage and benefits, and to control fraud and abuse in the system.

Quality assurance

Quality assurance standards should be required to ensure that tests are safe and effective.

Technology assessment and the development of medical practice guidelines should be encouraged to provide important information on the quality, effectiveness and cost-savings potential of cancer prevention and control services.

Cost containment

To ensure access to health care for people confronted by the cancer problem, it is essential that appropriate cost containment strategies be implemented at all levels to control excessive health expenditures.

Administration and financing

Increase the federal cigarette excise tax by at least $2.00 per pack as a means of financing changes in the health care system to expand health/cancer care access for all Americans and ensure an appropriate level of cancer-related services.

Administration of health care should be provided through an appropriate combination of public and private sector mechanisms that will improve access to such care.

The financing of universal health care should avoid placing disproportionate burdens on any individual or sector within society.

Medical research

In addition to health services research, health system reform should promote continued innovation and progress through medical research.

Senate Republican Health Care Reform Plan

This Analysis of the Senate Republican (GOP) plan is taken from an outline of the legislation and is subject to change. This Analyst was prepared on the date shown below. Previous Copies of this Analyst should not be referenced.

The assumptions made are those of the sponsors of the Senate GOP plan, and the American Cancer Society is basing its responses on those assumptions at this time. As more details about the plan become available, the America Cancer Society will be able to more closely examine the provisions to determine impact on cancer control. Future analyses may result in interpretations different from those contained in this document.

October 1, 1993

National Health Council—Mission and Goals

The National Health Council is a private, nonprofit association of national organizations which was founded in 1920 as a clearinghouse and cooperative effort for voluntary health agencies. To work more extensively for the public interest, the Council expanded its membership to encompass professional and other membership associations, health related nonprofit agencies, business corporations, and federal government agencies.

The Council's MISSION is one of enabling its member organizations to work together effectively to promote the health of all Americans with a strong sense of human concern, especially for vulnerable people.

Specifically, the Council strives to achieve the following GOALS:

1. To stimulate greater public awareness of health and health related concerns: a. by encouraging inquiry and research in health matters of mutual interest, and b. by disseminating health related information.

2. To strengthen cooperative efforts among health related private sector organizations, and between the private and governmental sectors: a. by facilitating the sharing of ideas, resources and leadership in the health field, b. by promoting a deeper appreciation of public policy issues and other extrinsic forces affecting health, and c. by maintaining open channels of communication

3. To foster collaborative activities among voluntary health agencies that will provide accountability and public confidence in their programs: a. by maintaining and monitoring high standards of public accountability, b. by assisting voluntary health agencies to meet such standards, c. by stimulating high levels of management performance, and d. by entering into selective advocacy on public policy matters affecting voluntary health agencies.

The National Health Council wants all Americans to take care of themselves and to use health resources wisely so that they can lead independent and productive lives.

Consumer Voice in Health Care Reform

In 1992, 37 million Americans had no health insurance. The number of uninsured, moreover, does not take into account the tens of millions of Americans now living with disease, disorder, or disability who daily encounter problems with our health care system. These individuals are the true victims of the health care crisis; yet, they are consistently denied access to care because of their pre-existing physical or mental conditions.

For over a year, thirty-two voluntary health agencies (VHAs) have come together through the National Health Council—an organization created 73 years ago to improve the health of all Americans, particularly those most vulnerable in society. These VHAs put aside their individual concerns in favor of cooperation to draft a

set of principles that we assert must be included in every health care reform proposal.

Throughout the health care reform debate, the consumer voice has been missing. Altogether, the voluntary health agencies listed to the side represent over 150 million Americans and their families who cope with serious and chronic conditions. As a group, we urge President Clinton and the Congress to consider our principles and guarantee their inclusion in the health care reform debate and final solution.

Be it resolved: Consumers must be afforded an active role in the formation of national health care policy; therefore, the undersigned Voluntary Health Agency (VHA) Members of the National Health Council call upon the Congress and the President of the United States to enact comprehensive health system reform embracing the following principles:

Eligibility: Health care is a right for all Americans. Our national health care system must guarantee universal access, regardless of employment status, ability to pay, or pre-existing conditions.

Personal health and public education: Individual responsibility for health is crucial to an effective health care system. All sectors of society, both public and private, must be encouraged to provide comprehensive health education, thereby empowering individuals to become active and aware of their responsibility for positive health behavior, disease prevention, and maintenance of healthy lifestyles.

Coverage and benefits: Coverage must address the continuum of mental and physical health care including preventive, acute, chronic, rehabilitative, and long-term care.

Health care services should be effective, appropriate, and timely. Medical effectiveness is defined by research findings. Appropriateness is determined by the patient, the family, and the health care team.

Health care plans and benefits should be portable so that continuity of coverage is not affected by changes in an individual's employment, geographic location, physical or mental condition, dependent status, or ability to pay.

Health care system reform must include incentives to encourage a more equitable distribution of health care providers to ensure access to care in rural, inner city, or otherwise underserved areas.

Cost Containment: The administration of the health care system must facilitate patient access to care. The administrative process of the health care system must be simplified and standardized for all payers, thus reducing costs and maximizing resources for actual health care services.

To ensure universal access, reimbursement to providers should reflect fairly the costs of providing services.

Medical liability reform is essential to ensure availability of health care services and to reduce the need for and burden of defensive medicine.

Results of outcomes research and technological assessment studies should be analyzed regularly to determine the efficacy of procedures, equipment, and drugs used in the diagnosis and treatment of illness.

Financing: The financing of universal health care should avoid placing disproportionate burdens on any individual or sector within society.

The CHAIRMAN. I recognize Senator Pell, who has another engagement and just wanted to ask a question.

Senator PELL. Thank you very much, Mr. Chairman.

I just had one question, really, for Ms. Joyner, whom I have long admired. Is the direct relationship between physical fitness and health is as real as you believe, or can you sometimes find people who are not physically active, who seem to do just as well?

Ms. JOYNER. I think there is a great relationship between those who are physically fit and those who are not. No. 1, if you take the statistic of those suffering from heart disease, certain cancers, women with osteoporosis, they were not educated on how to become involved in how to become involved in some type of physical activity, which can prevent the onset of those diseases.

So yes, the benefits of exercise in connection with a good diet can help prevent the diseases that are killing so many Americans daily.

Senator PELL. I come from this State where, I think more than many other States, people are less active and more sedentary, and

I was just curious as to how you thought we could turn people around.

Ms. JOYNER. Well, when you look at the State of Illinois, it is the only State that requires some kind of physical education curriculum for children from kindergarten through 12th grade. Well, that is disturbing because a lot of the programs have been cut, and what we are seeing for the last 10 years is unfit children; that kids involved in physical activities have declined. It is disturbing that we are putting lunch programs together that are making the statistics go up even higher, where we have added more fat to the kids' diets, they are not exercising. What is the solution? Putting more physical fitness activities into the schools. It should mandatory. There should not be only one State where it is required; we should take a better look at the State of health of kids throughout the country.

Senator PELL. Thank you. I think if we follow your advice, we will have fewer what we call "couch Americans."

Ms. JOYNER. Couch potatoes.

Senator PELL. And I appreciate the chairman letting me come in this way out of order.

[The prepared statement of Senator Pell follows:]

PREPARED STATEMENT OF SENATOR PELL

Mr. Chairman, I thank you for holding today's hearing on a topic near and dear to my heart: the role of prevention and wellness in a reformed health care system. I am particularly glad that Secretary Shalala is here to testify on this important subject, and believe that her presence is an indication of the importance that the President and First Lady attach to the role of prevention and wellness in our health care system.

I have several questions that I would like to ask Secretary Shalala regarding mammograms, pap smears, and other preventive services, after she completes her testimony. So I will defer any further remarks to that time.

I do want to thank all of today's witnesses for appearing and assure them, and you, Mr. Chairman, that this is an area of the President's plan—and of health care reform—that I intend to pursue fully in the coming months.

Thank you very much.

The CHAIRMAN. Thank you very much.

Dr. Francis.

Dr. FRANCIS. Thank you very much, Mr. Chairman.

On behalf of the American Heart Association, I would like to thank the committee for affording me the opportunity to be here today.

I am Dr. Charles Francis, a member of the American Heart Association Board of Directors and professor of clinical medicine at the College of Physicians and Surgeons of Columbia University, and chairman of the department of medicine at the Harlem Hospital Center in New York City.

The American Heart Association is a nonprofit, voluntary health organization, funded by private contributions. The goal of the association is to reduce disability and death from cardiovascular disease and stroke. To support this goal, the American Heart Associa-

tion has contributed more than $1 billion to cardiovascular research and has developed educational programs designed to promote health and to prevent and reduce the risk of heart disease and stroke.

The position of the American Heart Association to date has been guided by our five principles on access to health care. These are attached to my testimony. We feel these are critical to any health care reform package. We are pleased that the President's plan contains provisions addressing all of these principles, although we are still looking into the details of the plan.

We are also pleased to hear that the President and the First Lady talk about many of the objectives contained in our five principles, particularly the high priority given to preventive health benefits.

The administration has clearly taken a leadership role in setting the tone and direction for the debate on health care reform. It is clear that the administration is committed to improving health care for all Americans, and we are greatly appreciative of the effort and sincerity that the administration has given to this issue.

The focus of today's hearing provides the perfect opportunity to discuss our third principle of access to health care—"Coverage for preventive care must be part of any proposal for health care access," and there is indeed a critical need to have preventive health services made available to all Americans.

We believe that prevention can have a major impact on the health of all American people. This is especially true of heart disease and stroke because of the considerable available knowledge about methods to prevent these diseases.

Unlike many organizations that will undoubtedly testify at the numerous hearings on health care reform, the Heart Association has no special interest or for-profit motivation. What guides our position and our policies are the 250 million Americans who are candidates for cardiovascular disease and stroke.

As you know, Mr. Chairman, heart disease and stroke which are the number one and number three killers of Americans account for over 930,000 deaths each and every year. We know that behavior modification can reduce these deaths, and we know that preventive health services provide the most effective means of behavior modification.

The Heart Association has developed a package of basic preventive cardiovascular services that should be part of basic medical coverage. The benefit package that is attached to my testimony has been approved by our Heart Association scientific advisory council. This preventive package reflects accepted procedures and principles for the prevention of cardiovascular diseases.

The National Heart, Lung and Blood Institute's National Cholesterol Education Program's Adult Treatment Panel II update, released in June of this year, confirms the AHA's recommended preventive services package.

In the past 3 decades, great strides have been made in the prevention and treatment of heart disease, with a resulting decline in cardiovascular deaths, mainly attributed to lifestyle changes. People are paying much more attention to modifiable risk factors such as high cholesterol, cigarette smoking, hypertension, physical inac-

tivity, obesity, and elevated blood sugar. If the current health care reform debate stresses the implementation of preventive measures, we anticipate a major impact on the health of individuals and the public.

The Heart Association believes that a basic medical plan should include the following basic cardiovascular preventive services: blood pressure checks, cholesterol screenings, electrocardiograms, exercise stress testing, counseling, and medications, of course. We do not believe that every procedure should be available on demand, and the attached document provides in detail when and for whom these procedures should be done.

I would like to stress the importance of counseling at the primary care level. Periodic preventive counseling regarding the intake of fat, cholesterol, complex carbohydrates, sodium, potassium, and caloric balance, and the need for a regular exercise program, is critical. For those people who are at high risk with high cholesterol levels, we recommend that dietary therapy with monitoring and long-term follow-up by a physician, a registered dietician, or a licensed nutritionist be covered under the health plan.

I would also like to mention the importance of primary prevention of hypertension. As a member of the Fifth Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure—commonly referred to as JNC-5—we recommended that for people who are at high risk for the development of hypertension, particularly African Americans, persons with high normal blood pressure or with a family history of hypertension, that they moderate their sodium intake, reduce consumption of calories, increase regular physical activity, and moderate alcohol consumption.

Providing coverage for counseling on tobacco prevention and cessation is also very important to the AHA. Tobacco use is the number one preventable cause of death in the United States, and we know that most smokers would like to quit but cannot.

We also know that smoking cessation programs work and that they are cost-effective. But AHA believes that only proven and effective programs should be covered and only if they are conducted by appropriate and qualified individuals.

In fact, the Agency for Health Care Policy and Research is now developing practice guidelines on smoking cessation and prevention.

We are presented with a great opportunity now to provide encouragement to smokers to quit. That, coupled with increased excise taxes and increased regulation of tobacco products by the FDA, would have a tremendous impact on decreasing tobacco use throughout the country.

At the present time, as a result of the tremendous political influence of the tobacco industry over the year, there is no Federal agency that regulates tobacco products for health and safety purposes. This is in spite of the fact that tobacco accounts for over 400,000 deaths and is the single most preventable cause of death in our society.

It is time to change this scenario, time to provide the public with assurances and protections that we provide for other chemical substances in the marketplace. I hope, Mr. Chairman, that the tobacco

issue and its importance to public health does not get lost in the health care reform debate. Too many Americans have died because Congress has failed to pass legislation to adequately regulate this product, and many more will die if action is not taken.

Mr. Chairman, prevention, both educational and for the medical profession and other health providers, has an integral role to play in health care reform. The American Heart Association has public education programs to inform people and providers on how to reduce risks of heart diseases. These efforts would be greatly complemented by a comprehensive health care plan, public education programs which are accessible to all and that include preventive cardiovascular health care as outlined in our attached documents.

Thank you very much for your time and consideration.

The CHAIRMAN. Thank you very much.

[The prepared statement of Dr. Francis follows:]

PREPARED STATEMENT OF DR. CHARLES K. FRANCIS

On behalf of the American Heart Association, I would like to thank the committee for affording me the opportunity to be here today. I am Dr. Charles Francis, a member of the AHA Board of Directors and Professor of Clinical Medicine at the College of Physicians and Surgeons of Columbia University and Chairman of the Department of Medicine at the Harlem Hospital Center in New York City.

The American Heart Association is a non-profit, voluntary health organization funded by private contributions. The goal of the association is to reduce disability and death from cardiovascular diseases and stroke. To support this goal the AHA has contributed more than one billion dollars to cardiovascular research, and has developed educational programs designed to promote health, and to prevent and reduce the risk of heart diseases and stroke.

The position of the AHA to date has been guided by our five principles on Access to Health Care, which are attached to my testimony, and which we feel are critical to any health care reform package. We are pleased that the President's plan contains provisions addressing all of these principles, although we are still looking into the details of the plan. We are also pleased to hear the President and the First Lady talk about many of the objectives contained in our five principles, particularly the high priority given to preventive health benefits.

The Administration has clearly taken a leadership role in setting the tone and direction for the debate on health care reform. It is clear that the Administration is committed to improving health care for all Americans, and we are greatly appreciative of all the work, effort, and sincerity that the Administration has given to this issue.

The focus of today's hearing provides the perfect opportunity to discuss the AHA's third principle of Access to Health Care: "Coverage for preventive care must be part of any proposal for health care access", and that there is a critical need to have preventive health services made available to all Americans.

We believe that prevention can have a major impact on the health of the American people. This is especially true of heart disease and stroke because of the considerable available knowledge about methods to prevent them.

The need for access to preventive services is plain in the face of the fact that there are 250 million Americans who are candidates for cardiovascular disease and stroke. As you know, Mr. Chairman, these two diseases, which are the No. 1 and No. 3 killers of Americans, account for more than 930,000 deaths each and every year. We know that behavior modification can reduce these deaths and we know that preventive health services provide the most effective means of behavior modification.

As advocates for people who suffer from cardiovascular diseases and their families, we are pleased that we are seeing progress in research, education and healthier lifestyles. Unfortunately, we still face daunting problems:

- In 1990, heart and blood vessel diseases killed more than 930,000 Americans—more than two out of every five deaths.
- Of the current U.S. population of about 250 million people, more than 70 million suffer some form of cardiovascular disease, in many cases with a reduction of the quality of life.

- Heart diseases and stroke are not only a threat to the elderly. More than 161,000 Americans under the age of 65 die from cardiovascular disease each year.
- Cardiovascular diseases and stroke cost $117.4 billion in 1993, which includes $75.2 billion for hospital and nursing home services; $17.9 billion for physician and nurse services; $6.7 billion for drugs; and $17.6 billion in lost productivity.

In the past three decades, great strides have been made in the prevention and treatment of heart disease with a resulting decline in the cardiovascular death rates, mainly attributed to lifestyle changes. But, since up to 50% of heart attack victim's first warning is sudden death, there is little opportunity for treatment, and prevention offers the only hope.

In 1990, an estimated 392,000 coronary artery bypass procedures were performed on 262,000 patients at an estimated expenditure of over $9 billion. Should all heart attack prone individuals be treated surgically, resources to defray the costs would not be available. This is true, even more so, for heart transplants, which constitute a frequent treatment for end-stage heart disease. The technological treatments for heart disease such as angioplasty, thrombolytic therapy, antiarrhythmic drugs, and pacemakers are not curative. More importantly, such procedures can do nothing about the underlying process, atherosclerosis (the hardening of arteries), which is the principal cause of the problem.

It seems obvious that more effort should be directed to preventive approaches. Atherosclerosis begins in young adulthood and it may be decades before clinical disease is manifest. While we do not fully understand all of the causes of heart disease, large epidemiologic studies have identified risk factors and strategies to reduce the risk. These modifiable risk factors include high total cholesterol levels in the blood, cigarette smoking, hypertension, and physical inactivity.

There has been a significant reduction in cardiovascular mortality in the U.S. due, in large part, to the public's adopting a more healthful lifestyle. This underscores the importance of encouraging the medical profession to assume a preventive posture. More and more evidence is accumulating showing that atherosclerotic plaques in arteries can regress even in individuals with advanced disease.

Unlike many organizations that will undoubtedly testify at the numerous hearings on health care reform, the AHA has no special interest, or for-profit motivation. What guides our position and policy are the 250 million Americans who are candidates for heart disease and stroke.

We have developed a package of basic preventive cardiovascular services that we believe should be a part of basic medical coverage. The benefit package that is attached to my testimony has been approved by the AHA Science Advisory Committee, and it reflects accepted procedures and principles for the prevention of cardiovascular diseases. The National Heart, Lung and Blood Institute's National Cholesterol Education Program (NCEP)'s Adult Treatment Panel II update, released in June of this year, confirms the AHA's recommended preventive services package.

The AHA believes that a basic medical plan should include the following basic cardiovascular preventive services: blood pressure checks, cholesterol screenings, electrocardiograms, exercise stress tests, counseling and medications. We do not believe that these procedures should be provided to everyone on demand; the attached document details when and for whom these procedures should be done.

I would like to stress the importance of counseling at the primary care level. Periodic preventive counseling regarding the intake of fat, cholesterol, complex carbohydrates, sodium, potassium, and caloric balance and the need for a regular exercise program is critical. For those people who are at high risk with high cholesterol levels, we recommend that diet therapy with monitoring and long-term follow-up by a physician, registered dietician or licensed nutritionist be covered under the health plan.

Preventive services can also make a large impact on recurrence of disease in those who have already had a heart attack or surgery. The AHA urges the committee to insure that that coverage is available for secondary preventive services, namely, treatment after an angioplasty. We believe that patients who have already been treated for cardiovascular disease should have health care coverage for diet counseling, drug therapy counseling, rehabilitation, smoking cessation and exercise counseling. Clearly, secondary prevention measures are highly cost effective, as well as an essential treatment for patients who we know are in trouble.

Providing coverage for counseling on tobacco prevention and cessation is also very important to the AHA, and we have noted that President Clinton's plan would include this under the substance abuse treatment benefit. Tobacco use is the leading cause of preventable death and disability in the United States. We are presented with a great opportunity right now to provide the encouragement that they need.

Each year tobacco use kills 434,000 Americans and burdens our health care system with $65 billion in direct medical costs and lost productivity. Tobacco use is linked to heart disease, high blood pressure, stroke, cancer of the lung, larynx, trachea, pancreas, bladder and lip and respiratory diseases. Smokers also have increased problems with colds, pneumonia, influenza and bronchitis.

But above and beyond the need to ensure coverage for smoking cessation, there are other equally important public policy initiatives that need to be addressed if we are to deal with the tremendous tobacco problem in this country. I would be remiss if I did not bring these issues to the attention of the Committee. Clearly Congress needs to take the tobacco industry head on. The AHA, along with its sister agencies the American Cancer Society and the American Lung Association, believe that tobacco must be regulated in the manner in which other legal products in our society are regulated, including the way they are manufactured, distributed, sold, labeled, and advertised. FDA should be given specific authority over tobacco products. It is indeed a national health travesty that this nation's single most preventable cause of death is also the least regulated. As long as this product remains exempt from health and safety laws passed by Congress and designed to protect consumers, the tobacco industry will have free reign to market its products while realizing huge profits at the expense of hundreds of thousands of lives lost each and every year.

The tax on cigarettes should also be significantly increased. The AHA strongly supports an increase in the cigarette excise tax of $2 per pack, to help finance health care reform and to reduce consumption. For every ten percent increase in the price of tobacco products, there will be approximately a four percent decrease in tobacco consumption and possibly a greater decrease by children.

And, when it comes to tobacco and the prevention of disease, we are no longer just talking about the smoker but the nonsmoker as well. As you know, in January of this year the EPA released a report that concluded that environmental tobacco smoke (ETS) has a serious and substantial impact on the public's health. ETS is now listed as a known human carcinogen along with asbestos, benzene, and arsenic. The EPA report found that children who are exposed to ETS are at a higher risk for lower respiratory tract infections, ear problems, and new and increased symptoms of asthma. The AHA estimates that 35,000 to 40,000 cardiovascular disease-related deaths occur each year as a result of ETS.

Mr. Chairman and members of this Committee, we must do more to protect our citizens and particularly our children from the ravages of tobacco. After allowing the tobacco industry to control the tobacco and health agenda in Congress for the last 40 years, the opportunity exists for "change." Do not let the tobacco industry hold health care reform hostage to its special interests. Too many Americans have died because Congress has failed to act. Many more will die if Congress does not intervene.

Mr. Chairman, prevention—both educational and medical—has an integral role to play in health care reform. The AHA has public education programs to inform people how to reduce their risk of heart disease. Countless numbers of posters, brochures, booklets, advertisements and kits targeted to schools, businesses and health care sites reach millions of Americans every year with educational messages promoting good heart health. The AHA's community service programs educate the public on how to control high blood pressure, stop smoking, adopt healthy dietary habits and be physically active.

These efforts will be greatly complemented by a comprehensive health care plan, accessible to all, that includes preventive cardiovascular health care as outlined in the attached document.

President Clinton has emphasized the need for preventive care research as a part of his health care reform proposal. The AHA believes that the allocation of funds for biomedical research is pivotal to any health care reform plan.

Without continuing research, we will not be able to improve the diagnosis and treatment of cardiovascular diseases. We will only make critical advances if biomedical research, research tag and clinical training are recognized as integral parts of health care reform.

We recognize, as well, that biomedical research is essential to the development of preventive measures. Recent developments in molecular and genetic cardiology indicate that the near future will present the opportunity for highly cost-effective preventive interventions, targeted to high-risk individuals with identified genetic predisposition to disease, before the development of clinical disease states. An early example will be familial hypercholesterolemia.

The AHA wants to participate in the development of guidelines for appropriate, quality cardiovascular care and see more research on methods to measure quality, outcomes and cost-effectiveness. We believe that professional groups, such as the AHA, should be an important part of guideline development. Proper, effective and

cost efficient care is necessary if the United States is going to find a solution to the health care crisis we are facing today.

The American Heart Association, in conjunction with the American College of Cardiology, has already developed ten practice guidelines on procedures ranging from electrocardiography to exercise testing to coronary angiography and by-pass surgery. The AHA and ACC are currently working on additional guidelines. The AHA would be happy to provide copies of guidelines to the committee at your request.

Death rates from heart attacks, among both men and women, have gone down substantially in the last twenty years. These statistics are the result lifestyle changes by the public and advances in medical technology and therapy. Health care providers play an important role identifying people at high risk for cardiovascular disease and encouraging them to modify their behavior. However, there is much to be done in the area of outcomes research. The New England Journal of Medicine notes that "further research about the overall risk-benefit ratios of these interventions and the development of effective strategies to help implement risk-factors modifications are needed."

The AHA is prepared to assist the committee as it proceeds in the health care reform debate. We will be happy to provide you with more information on any of our programs at your request.

PREAMBLE TO BASIC PREVENTIVE CARDIOVASCULAR SERVICES

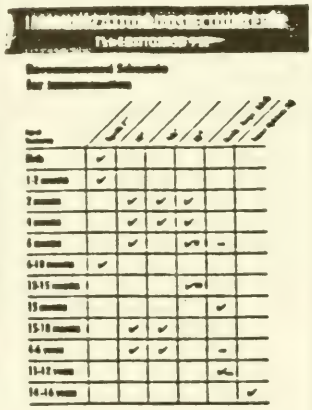
In the past three decades great strides have been made in the prevention and treatment of heart disease with a resulting decline in cardiovascular deaths, mainly attributed to lifestyle changes. Because approximately half of all deaths from heart disease are sudden and unexpected, there is little opportunity for treatment in this group, and prevention offers the only hope. In 1990 an estimated 392,000 coronary artery bypass procedures were performed on 262,000 patients at an estimated expenditure of over $9 billion. Should all heart attack-prone individuals be treated surgically, resources to defray the costs would not be available. This is even more true for heart transplants. The technological treatments for heart disease such as angioplasty, thrombolytic therapy, antiarrhythmic drugs, and pacemakers are not curative. More importantly, procedures can do nothing about slowing the underlying process, atherosclerosis, which is the principal cause of the problem.

It therefore seems obvious that more effort should be directed to preventive approaches. Atherosclerosis begins in young adulthood and it may be decades before clinical disease is manifest. While we do not fully understand all of the causes of heart disease, large epidemiologic studies have identified risk factors and strategies to reduce the risk, these have been proposed and tested. The modifiable risk factors include high cholesterol levels in the blood, cigarette smoking, hypertension, physical inactivity, obesity, and elevated blood sugar. There has been a significant reduction in cardiovascular mortality in the U.S. due, in large part, to the public adopting a more healthful lifestyle. This underscores the importance of encouraging the medical profession to assume a preventive posture. More and more evidence is accumulating showing that atherosclerotic plaques in arteries can regress even in individuals with advanced disease. As our understanding of the causes of heart disease and stroke improves, the day will come when we are able to direct preventive measures at the pathology of the disease. The opportunity to reduce the major causes of morbidity and mortality from heart disease and stroke is at hand. Through the implementation of preventive measures we can have a major impact on the health of the individual and the public. This is especially true of heart disease and stroke because of the considerable available knowledge about methods to prevent them. Although a cost has not been placed on preventive services, it seems logical that they would cost less than the present medical system which is primarily responsive to established disease through expensive interventions.

The American Heart Association believes that an equitable comprehensive health care plan, accessible to all, should include as an integral part, basic preventive health care services as outlined.

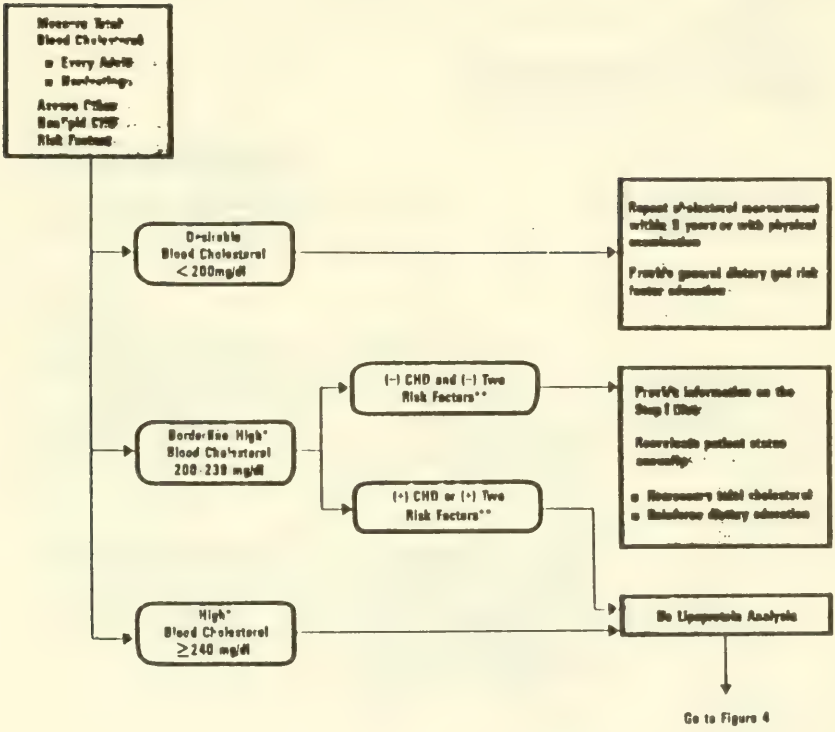
DRAFT
AMERICAN HEART ASSOCIATION
BASIC CARDIOVASCULAR PREVENTIVE SERVICES
CHILDHOOD THROUGH ADULTHOOD

	BIRTH TO 20 YEARS OF AGE	20 YEARS OF AGE AND OLDER
Medical History		
Identification of Early Symptomology Including Counseling	Birth, update at 2 years, then every 4 years up to age 20	Every 5 years, every 2 years between 61-75; every year after age 75
Physical Exam	Birth to 18 months (2,4,6,18 months); 2-6; 7-12; 13-14	Same as above.
Growth Chart (Children)	Birth, ongoing up to 13	
Height & Weight	13-18	Weight As part of physical exam
Blood Pressure		
Apparently Healthy	Age 3, every examination thereafter	If BP<130/<85 mmHg every 2 years
High Risk	Physician monitoring and follow-up at every physical	BP 130-139/85-89 mmHg every year 140-159/90-99 mmHg confirm within two months (See attached schedule per JNC V)
Screening for Lipid Levels		Total Cholesterol and HDL
If Apparently Healthy		Ages 20-60 every 5 years Ages 61-75 and over optional
*If At High risk		
After age two children of parents with ≥240 mg/dl total cholesterol	Total cholesterol	
Adults with cholesterol between 200-240 mg/dl without other risk factors		Recheck annually, dietary information (see attached schedule)
*Fasting Lipid Profile:		
At two years of age, children with cholesterol ≥200 mg/dl or because of a documented history of premature cardiovascular disease in parent, grandparent, aunt or uncle, age 55 or less	Immediately	Reevaluate annually (see attached shcedule)
Adults with cholesterol between 200-239 mg/dl and with other risk factors, or with cholesterol ≥240 mg/dl.	Immediately	Reevaluate annually (see attached schedules)
Fasting Plasma Glucose		
Apparently Healthy		Every 5 years up to age 75, thereafter optional
High risk individuals between 110-130% above desirable weight with cardiovascular disease and abnormal lipid profile		Every 2-1/ years up to age 45, yearly after age 50.
Resting ECG		One (baseline) by age 40
High Risk		
Two or more risk factors and family history of premature coronary heat disease		
*New recommendations will be available from National Cholesterol Education Program (NCEP) later in 1993		
Exercise Stress Tests		
High Risk		High risk individuals who have 2 or more risk factors or strong family history of premature coronary heart disease or over age 40 who are planning to be in a vigorous exercise program, or those who would endanger public safety were they to experience sudden cardiac events e.g. airline pilots, fire fighters

	BIRTH TO 20 YEARS OF AGE	20 YEARS OF AGE AND OLDER
Counseling		
Apparently Healthy	Parents of children of all ages, introduce AHA low fat diet at age 2; effects of passive smoking, risks of obesity, physical activity. Parents and Children age 6 and over should be counseled on diet, tobacco and substance use, physical activity and alcohol.	Periodic preventive counseling regarding dietary intake of fat, saturated, cholesterol complex carbohydrates, sodium, potassium, caloric balance, selection of an exercise program, tobacco avoidance or cessation, alcohol and cocaine use. Use of seat belts
High Risk	Children with high blood pressure and their parents should receive counseling on diet and exercise. Children with hyperlipidemia will require nutritional guidance and monitoring by a registered dietitian or licensed nutritionist, long term follow-up of lipid levels and identification and avoidance of other CV risk factors. (Follow NCEP Guidelines)	Diet therapy (AHA Step 1 and 2 diets) should be initiated in individuals with cholesterol levels between 200-240 mg/dl and over 240 mg/dl with monitoring and long term follow-up by a physician and a registered dietitian or licensed nutritionist. (Follow NCEP guidelines).
Medications		
High Risk	Elevated cholesterol levels based on NCEP guidelines indicate the need for drug therapy. It may be considered for children 10 years of age and over who have LDLC levels higher than 190 mg/dl or >160 mg/dl and either a strong family history of premature CHD or two or more adult CVD risk factors. These children should be treated by physicians experienced in the management of lipid disorders in children.	Cholesterol lowering drugs should be considered in patients with persistent dyslipidemia based on NCEP guidelines and in many patients with established or known coronary artery disease. Pharmacologic treatment will be needed for individuals whose response to lifestyle modifications for blood pressure lowering are inadequate. Adequate compensation for drugs should be provided as needed
Immunizations	Should be available for all children	
		
	Pregnant women lacking proof of vaccination after the first birthday or laboratory evidence of immunity should receive rubella vaccines.	
Antibiotic prophylaxis		
High Risk Children with Group A Streptococcal Infection	Penicillin	Influenza-Pneumocal Age 65 and over; high risk groups
History of Acute Rheumatic Fever	Penicillin Prophylaxis	
Valvular heart disease with procedures	Penicillin with procedures	

FIGURE

3 — *Initial Classification Based on Total Cholesterol*



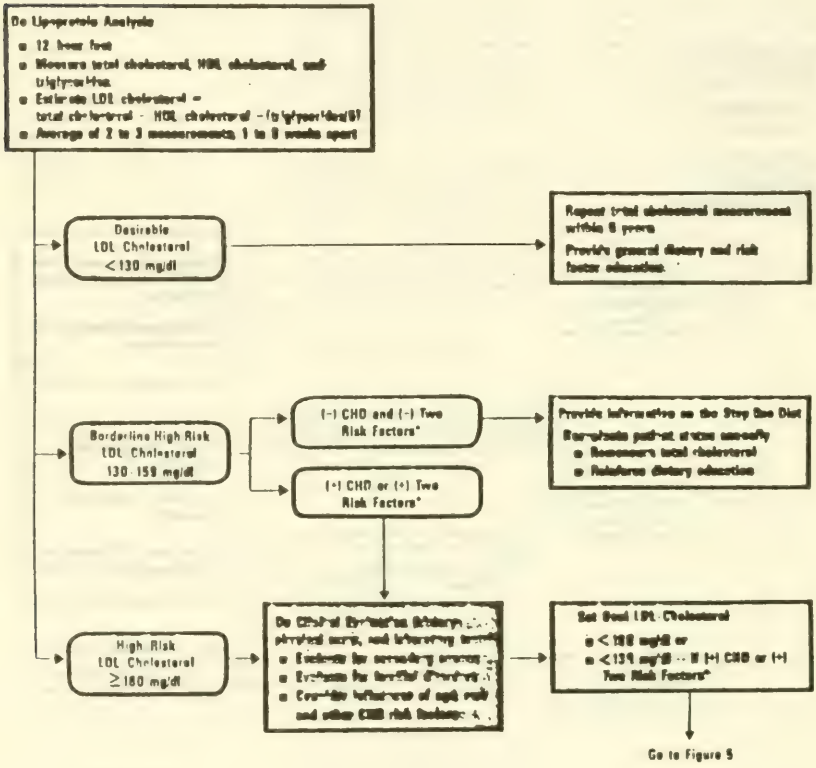
Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults, USHS, NIH, Jan., 1989.

*Must be confirmed by repeat measurement; use average value.

**One of which can be male sex (see Table 2).

FIGURE

4 — *Classification Based on LDL-Cholesterol*



*One of which can be male sex (see Table 2)

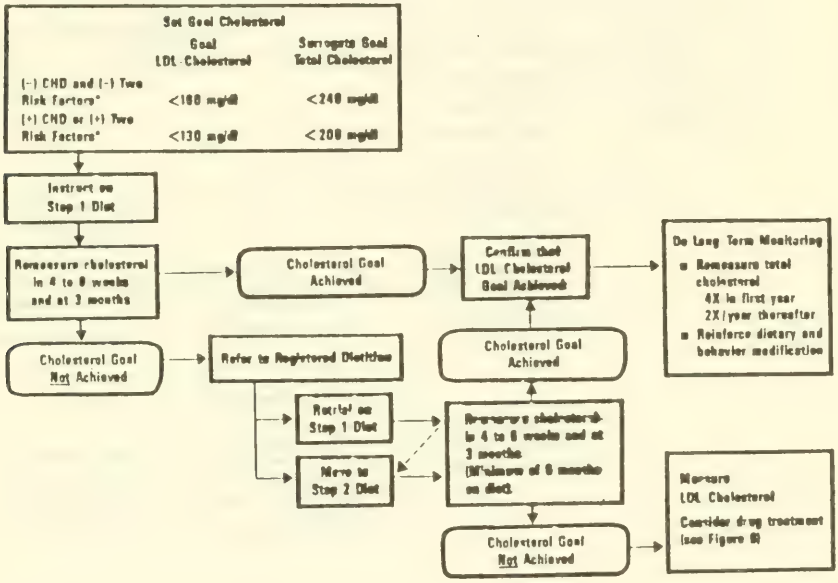
4. *Inadequate Response to Diet*

A patient who fails to achieve the goals for lowering of total cholesterol (or LDL-cholesterol) by dietary therapy should be classified as having an inadequate response to diet. This does not necessarily mean diet failure, because a significant reduction in cholesterol levels may have occurred by diet modification. There are four categories of inadequate response to diet that can be distinguished.

(1) Patients who have severe elevations of serum cholesterol often cannot achieve the goals of serum cholesterol lowering by diet, no matter how strict the diet. For these patients (see Appendix II), it is not necessary to wait for six months of dietary therapy before adding drugs to the regimen.

FIGURE

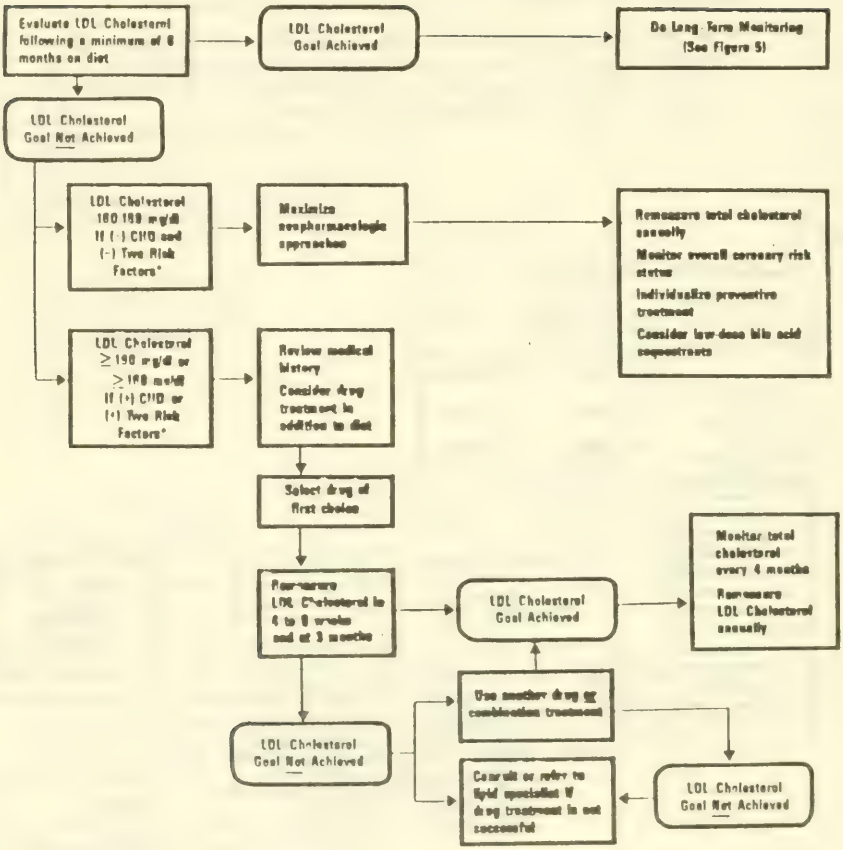
5 — *Dietary Treatment*



* One of which can be male sex (Table 2)

FIGURE

6 — *Drug Treatment*



*One of which can be male sex (Table 2)

TABLE 4. RECOMMENDATIONS FOR FOLLOWUP BASED ON INITIAL SET OF BLOOD PRESSURE MEASUREMENTS FOR ADULTS AGE 18 AND OLDER

Initial Screening Blood Pressure (mm Hg)*		
Systolic	Diastolic	Followup Recommended†
<130	<85	Recheck in 2 years
130-139	85-89	Recheck in 1 year**
140-159	90-99	Confirm within 2 months
160-179	100-109	Evaluate or refer to source of care within 1 month
180-209	110-119	Evaluate or refer to source of care within 1 week
≥210	≥120	Evaluate or refer to source of care immediately

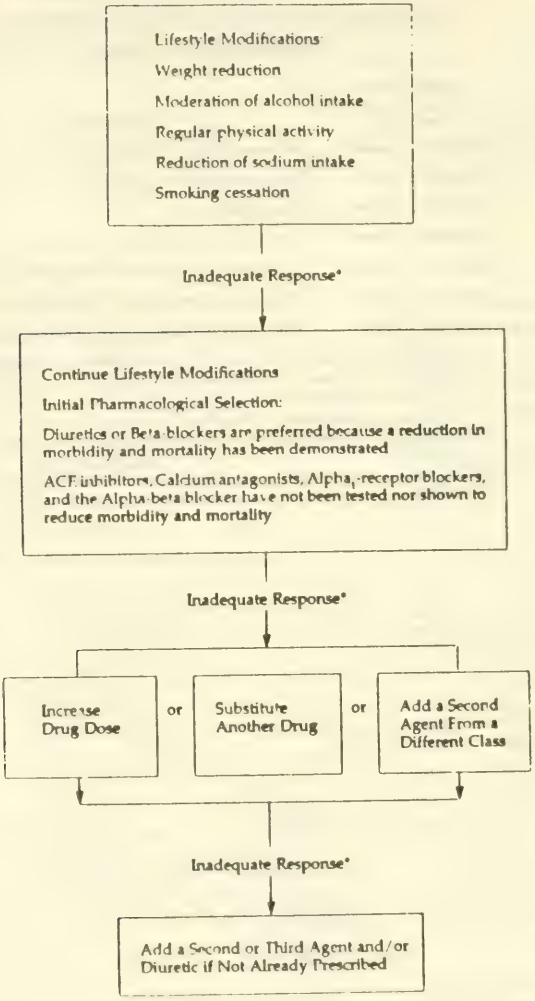
* *If the systolic and diastolic categories are different, follow recommendation for the shorter time followup (e.g., 160/85 mm Hg should be evaluated or referred to source of care within 1 month).*

† *The scheduling of followup should be modified by reliable information about past blood pressure measurements, other cardiovascular risk factors, or target-organ disease.*

** *Consider providing advice about lifestyle modifications (see Chapter III).*

Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure (V), NIH NHLBI, Jan., 1993.

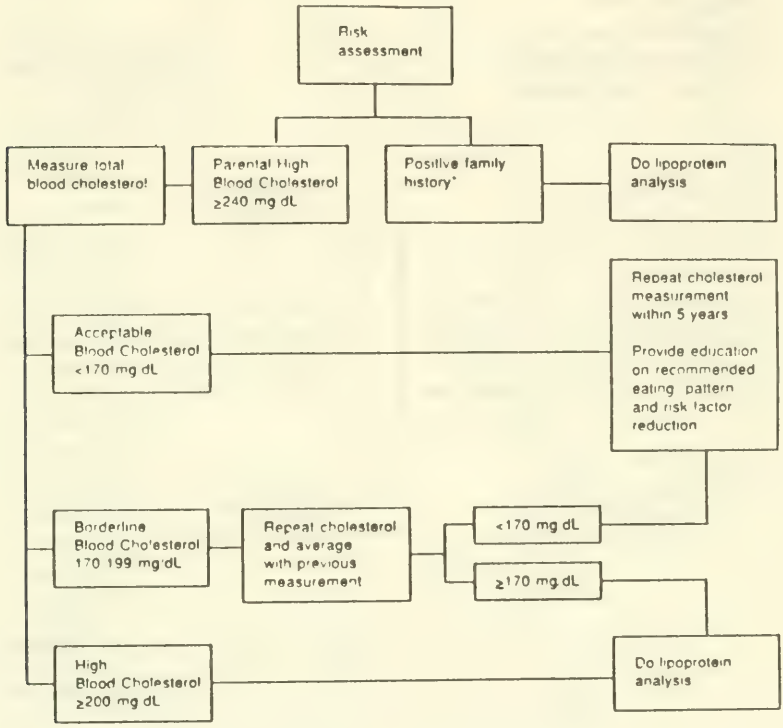
FIGURE 4. TREATMENT ALGORITHM



* *Response means achieved goal blood pressure, or patient is making considerable progress towards this goal.*

Figure 1

Risk Assessment



Highlights of the Report of the NCEP, USHS, NIH, 1991.

* *Defined as a history of premature (before age 55 years) cardiovascular disease in a parent or grandparent*

Figure 2

Classification, Education, and Followup Based on LDL-Cholesterol

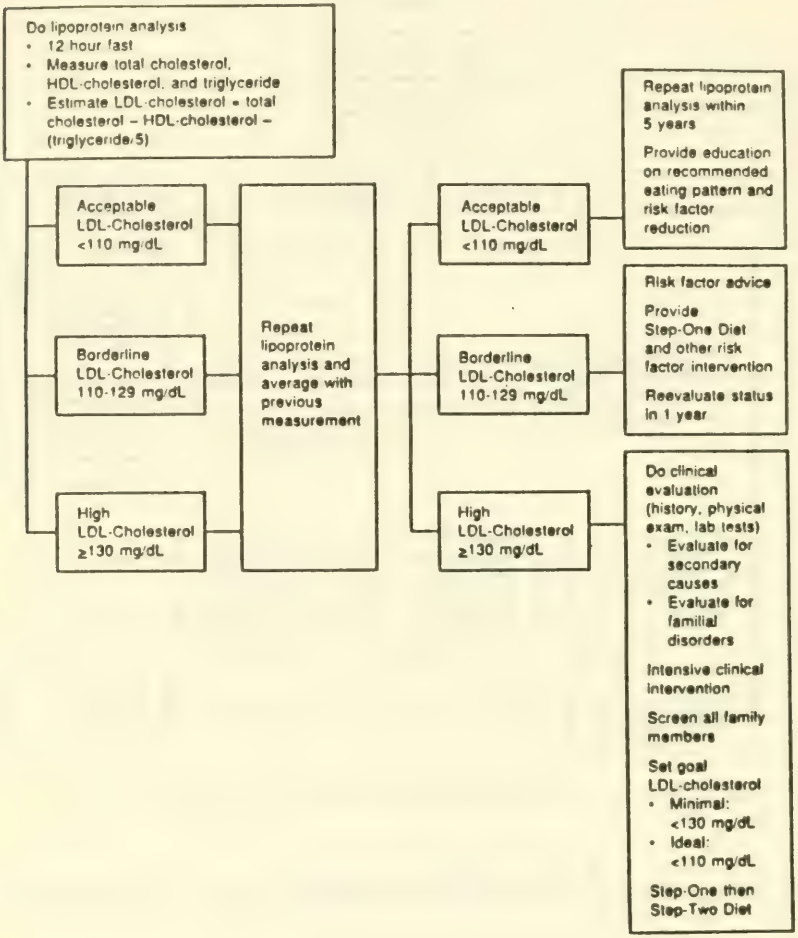
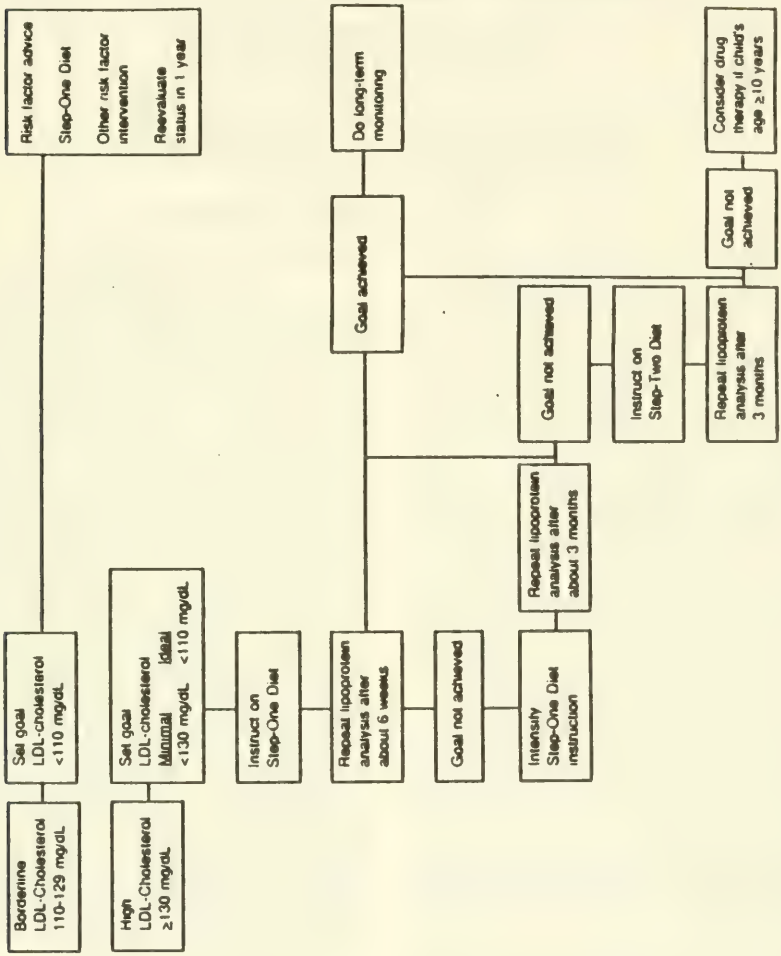


Figure 3

Diet Therapy



Position Statement

Principles of Access to Health Care

Access to Health Care Task Force, American Heart Association

Harriet P. Dustan, MD, and Charles W. Francis, MD, Cochairs; Hugh D. Allen, MD; Susanna L. Cunningham, PhD, RN; William Dulany, Esq.; Joel Hay, PhD; Gerard A. Kaiser, MD; Thomas H. Lee, MD; Pamela Mattson, JD; David A. Ness; and Anthony G. Wagner, Members
Richard Hamburg; Sarah Kayson; Rodman D. Starke, MD; and Kathryn A. Taubert, PhD, AHA staff

Principle 1: All United States Residents Should Have Access to Quality Medical Care

It is widely agreed that the United States leads the world in terms of its medical care expertise. America's physicians and other health care professionals are among the world's best trained, our hospitals are among the world's best equipped, and our biomedical researchers are constantly testing the limits of the world's scientific knowledge; yet among industrialized countries the United States does not have the lowest infant mortality nor the longest life expectancy.

Many would argue that this discrepancy is at least partly due to the fact that many of America's less fortunate residents do not have access to basic health care, including basic cardiovascular care. Many obstacles deter entry into the health care system and utilization of many of its services, and often the services available may not be of high quality. Furthermore, for this population, access is too often delayed until the person is desperately ill and requires long and costly hospitalization. This forced delay results in diseases being treated rather than prevented. Individuals suffer needlessly, and our health care system bears additional, unnecessary costs because some of our nation's residents do not have access to the basic preventive medical care that can delay or prevent a disease's progression. A related problem is that some people may have access to care but do not take advantage of it for reasons such as cost, transportation or language barriers, bureaucracy, fear of the system, or lack of exposure to and education about what is available. The problem of access has many components.

The American Heart Association supports the position that regardless of preexisting conditions, all US residents must have access to quality medical care, including appropriate medications and prevention programs.

"Principles of Access to Health Care" was approved by the American Heart Association's Board of Directors on October 23, 1992.

Requests for reprints should be sent to the Office of Scientific Affairs, American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231-4596.

Principle 2: Universal Coverage for Basic Medical Care Should Be Available

According to the US Congressional Budget Office, in March 1990 about 37 million Americans had no insurance coverage, reflecting a tremendous growth in the number of uninsured persons in the 1980s. The Congressional Budget Office data permit some generalizations about the uninsured: Children account for approximately 25%; the majority have incomes at or below 200% of the poverty level; most have one or more family members in the work force; and although most are white, members of various minority groups are disproportionately more likely to be uninsured. Frequently the lack of health insurance coverage is temporary, such as when a person changes jobs or is temporarily unemployed. Minimum-wage jobs are unattractive to many because often health insurance is not a fringe benefit. This unavailability of health insurance, for example, would discourage a parent from leaving the welfare rolls to accept minimum-wage employment.

Although people may lack health insurance for a number of reasons, the consequences of being uninsured are often negative. Compared with the insured, the uninsured use the nation's health care system less frequently, are more likely to be without a regular source of basic health care, are less likely to engage in preventive measures, and are more likely to delay seeking medical care.

Of particular concern to the AHA is how the lack of health insurance affects basic cardiovascular care. Because the uninsured are less likely to seek basic medical care, they probably are less likely to receive basic cardiovascular care. The task force believes that when this care is not provided, in many cases people are more likely to suffer from preventable cardiovascular diseases and the nation's health care system incurs treatment costs that far exceed those of preventive care.

The AHA supports health care reform that includes universal coverage of basic medical care.

Principle 3: Coverage for Preventive Care Must Be Part of Any Proposal for Health Care Access

Over the last several decades researchers have identified a number of risk factors for cardiovascular dis-

eases, most of which can be modified or eliminated by appropriate interventions. Because cardiovascular diseases are the major cause of death in the United States, control of modifiable risk factors can improve the nation s health, prolong lives, and diminish health care costs. The magnitude of the potential benefit of such risk factor control is emphasized by the fact that in 1992 cardiovascular diseases afflicted more than one in four Americans and cost approximately $109 billion.

Cardiovascular diseases affect both adults and children. Atherosclerotic cardiovascular diseases, particularly coronary heart disease, are associated with elevated blood cholesterol, cigarette smoking, hypertension, diabetes, and lack of exercise. Control of these risk factors by lifestyle modification or medication lowers morbidity and mortality rates.

The occurrence of stroke is critically dependent on hypertension, and modern treatment programs have resulted in a striking decrease in stroke mortality rates. Other modifiable risk factors for stroke include smoking and excessive intake of alcohol.

Although the development of hypertension is strongly influenced by heredity, modifiable risk factors include obesity, excessive alcohol consumption, and, in susceptible people, high sodium intake.

Heart disease in children is either congenital or acquired. Although research has yet to define all the causes of congenital defects, it is known, for example, that both alcohol and cocaine use during pregnancy can cause specific heart lesions in the offspring. Abstinence from these two toxins during pregnancy would prevent many cases of heart disease in the newborn. Another preventable cause of congenital heart disease is rubella, or German measles, a risk that can be eliminated by immunization of the mother before pregnancy.

Rheumatic heart disease, the result of rheumatic fever, is a leading cause of acquired heart disease in children. Rheumatic fever is a preventable consequence of strep throat. Rheumatic heart disease can largely be avoided by preventing rheumatic fever through treatment of streptococcal pharyngitis with penicillin.

It is important to note that the adult cardiac problems discussed above can have roots in childhood, so appropriate measures for detection and control of risk factors should be part of basic pediatric and prenatal medical care. Prevention is the key to eliminating many cardiovascular diseases; therefore, the AHA strongly supports the coverage of preventive care as part of any access proposal. This would complement other AHA activities in the areas of public policy and public education related to preventive health care.

Because children have less access to health care than adults, equal access will require more resources than previously used. This will necessitate some redistribution of these resources. Children must be a high priority.

The AHA supports the position that resources must be targeted to the prevention of heart disease.

Principle 4: Funds Must Be Allocated for Biomedical Research, Research Training, and Clinical Training

High-quality health care and continuing improvement in diagnosis and treatment depend in large measure on the results of biomedical research. The AHA has long been a vigorous proponent for support of biomedical research and research training.

As part of the debate about plans for universal access to and universal coverage for health care, the AHA emphasizes that support of biomedical research and research training are necessary components of any national program. Results of past research are responsible for the improved health and longer lives of the American people. Future research can be relied on to improve diagnosis, prevention, and treatment of all diseases, making medical care more cost-effective. For example, polio vaccine has eliminated one scourge that crippled thousands of young people annually. The vaccine was developed when researchers learned how to grow the virus in the laboratory. Other examples include development of open-heart surgery, coronary bypass procedures, and thrombolytic and diuretic drugs.

Substantial benefits have been derived from biomedical research in this country. For this to continue, health care reforms must include support for 1) basic and clinical research at a level that allows reasonable growth, 2) research training at a level that eliminates the current downward trends in research manpower, and 3) resources adequate to supply needed equipment and other types of infrastructure.

To contain costs, Medicare rulings were changed to allow support of postgraduate training only through the first period of specialization. This ruling, along with other cost control measures, means that support of training for cardiac subspecialties and other needed cardiovascular care providers will be in jeopardy.

The AHA supports the position that funding for biomedical research, research training, and training of cardiovascular practitioners must be considered whenever health care reform is planned.

Principle 5: The American Heart Association Should Participate in the Development of Guidelines for Appropriate Patient Care and Should Support Research Into Methods of Measuring Quality, Outcomes, and Cost-Effectiveness

The AHA recognizes that there are limits to the resources that the United States can provide for health care. Neither private insurers nor government should be expected to provide medical care to all without considering the appropriateness, efficacy, or cost of treatment.

To ensure the quality and cost-effectiveness of the medical care provided, two general requirements must be met: 1) the development of practice guidelines by professional groups with the appropriate expertise, and 2) the knowledge of treatment outcomes generated by health services research to determine not only clinical effectiveness but also cost-effectiveness. Because health services research is a relatively new discipline, the number of trained researchers is small and knowledge is limited.

The AHA advocates the continued development and wide promulgation of basic practice guidelines by appropriate professional groups, the support of health services research, and the training of health services researchers.

The CHAIRMAN. Dr. Ludden.

Dr. LUDDEN. Mr. Chairman, thank you very much for the opportunity to testify before you today. I am here representing the Harvard Community Health Plan, which is a 545,000-member health maintenance organization which takes care of patients from New Hampshire, Rhode Island, and Massachusetts. We at HCHP believe that the reform of the U.S. health care system must include a reorientation of all of medical care toward prevention.

We know that inadequate attention to prevention makes us a sicker, poorer Nation and undermines the ultimate quality of our medical care. I do not think there will be anyone here who disagrees with that premise, and we have a solid foundation as a nation in the 1989 Guide to Clinical Preventive Services of the U.S. Preventive Services Task Force.

What has gone wrong? There is a problem, with two parts to it as I see it. First, without universal coverage, tens of millions of uninsured Americans do not have adequate access to preventive care or coverage and cannot afford simple preventive measures that will improve their health, so they delay, they cost more, and they use the most expensive medical resources.

Second, for those who are insured, preventive benefits are limited, and the fee-for-service system is designed to provide incentives for physicians to treat the sick, to treat very sick and illness, and not to engage in prevention counseling and education.

Therefore, we feel strongly that the essential first steps are to guarantee coverage of preventive care and to assure access to medical professionals who are oriented to prevention, as are found in the primary care specialties.

HMOs and other managed care organizations have been providing this kind of care since their inception. We provide and cover routine exams, screening tests, immunization, prenatal and well-child care, eye exams, allergy tests,, preventive dental visits for children for which our members pay either a small office visit fee of $5 to $10, or in the case of immunizations and prenatal care, no visit fee at all.

We also provide comprehensive mental health and substance abuse coverage, and we offer health promotion and education classes at nominal charge. These are the kinds of benefits the Clinton plan would provide for all Americans.

At HCHP, our preventive package becomes synonymous with our practice of medicine. It includes primary prevention, including immunizations against preventable diseases, doing risk assessment and behavior modification, secondary prevention, including outreach to patients and early detection of disease. Prevention like that can begin before birth, sometimes even before conception, when it comes to nutrition and other issues.

The third part of our preventive program includes the informed treatment of illness, including understanding factors that make treatment difficult and applying coordinated care, teamwork, and problem-solving, so that we are continuously improving outcomes.

And finally, preventive medicine includes the wise use of resources, avoiding unnecessary and ineffective care; it means basing clinical decisions on clinical and scientific assessment and never on cost alone. There is a lot less certainty in what preventive meas-

ures work, applied in what form, than one might hope. So we need to reach a consensus, and we base our practices at HCHP on a consensus which our group practice is able to achieve.

I would like to mention very briefly four things that are examples of the synonymous prevention and all of medical practice that we engage in at Harvard Community Health Plan.

As I mentioned before, we cover all immunizations and screening. Every new member receives a brochure—some of which are here—on staying healthy, that contains all of our recommendations for immunizations for screening tests for men, women, and children. We support compliance of our membership in that with a number of ways, using computer-generated reminders, sending postcards and notes to patients, or actually going out and finding them.

As the report card that I have attached to these materials shows, we measure our performance on a regular basis and use clinical quality improvement to help increase compliance and follow-up.

The second example included in the attached tables shows the improvement in our ability to follow up abnormal pap smears within 6 to 9 months so that we are now following up at a level of almost 99 percent across Harvard Community Health Plan compared with a typical benchmark of about 70 percent.

In managing illness as a piece of prevention, I would point to HCHP's AIDS program, which couples primary care providers who may know less about treating people with HIV with a central group of experienced resources, including nurses and education programs, available 24 hours a day. We have beginning evidence that the length of stay for hospitalizations for people with AIDS is significantly, perhaps up to a third, less than in the disorganized fee-for-service system, and that our total costs for caring for AIDS patients may be as low as half as great as those in the disorganized fee-for-service system, with satisfaction levels that are superior.

Finally, in all of these areas, we work to prevent the unnecessary use of resources in all the preventive maneuvers we look at. The example I have included in our handout is a collaborative effort between primary care physicians and specialty neurologists to look at using cranial imaging, MRIs and CTs, and through that kind of collaboration and teamwork, which is the heart of a group practice HMO, we are able to reduce the use of that test by about a third.

Ultimately, our goal should be to make health care in fact a much smaller piece of people's lives, in terms of incidence of illness, cost, and administrative hassle. A national strategy of prevention that is based on clear goals, coordinated processes of care, necessary follow-up, measurement of performance and continuous improvement, all supported by adequate funding, all of those will contribute to our goal.

Thank you for the opportunity to testify, and I would be glad to answer any questions.

The CHAIRMAN. We will come back to questions, but let me ask if you have smoking cessation in your program?

Dr. LUDDEN. Yes, many.

[The prepared statement of Dr. Ludden follows:]

John M. Ludden, M.D.
Medical Director
Harvard Community Health Plan

Testimony Before the Senate Committee on Labor and Human Resources
October 6, 1994

Mr. Chairman, members of the committee. Thank you for the opportunity to testify before you today. I am here representing Harvard Community Health Plan, a 545,000-member health maintenance organization serving Massachusetts, Rhode Island and southern New Hampshire.

We believe that reform of the U.S. health-care system must include a reorientation of medical care to prevention. Inadequate attention to prevention makes us a sicker, poorer nation, it undermines the quality of our medical care and it strains the relationship between patients and their physicians. In almost all cases, preventing disease is more humane and cost-effective than treating its consequences.

I think we would be hard-pressed to find anyone who disagrees with my premise. The value of prevention is strongly imbued in the classical view of medicine. Prevention as a national health-care strategy already has a solid foundation in the 1989 Guide to Clinical Preventive Services of the U.S. Preventative Services Task Force, which recommended 169 interventions that would help prevent 60 medical conditions. So what is missing? What has gone wrong?

The problem, in my view, is both economic and structural. Without universal coverage, tens of millions of uninsured Americans do not have adequate access to preventive care or coverage. Many cannot afford simple preventive measures that will improve their health and well-being. They delay or do not receive the care they need, and when they do receive care, they are likely to consume the most expensive medical resources, such as emergency room services.

For those who are insured, preventive benefits may be limited or non-existent, so prevention becomes a luxury rather than a given. Our traditional unorganized fee-for-service insurance system reimburses physicians for treating incidents of illness, not for preventive practices, counseling or patient education. In turn, these fee-for-service payment incentives have led to diminished interest in primary care among medical students and to a lack of coordination among specialties and levels of care. These are barriers to prevention that must be overcome.

The essential first steps are to guarantee coverage of preventive care and to ensure access to medical professionals who are oriented to prevention. HMOs have been providing that kind of care and coverage since their inception. We provide and cover routine examinations, screening tests, immunizations, prenatal and well child care, eye exams, allergy tests and treatment, and preventive dental visits for children, for which our members pay either a small office visit fee of $5 to $10, or in the case of immunizations and prenatal care, no visit fee. We also provide comprehensive mental health and substance abuse coverage, and we offer health promotion and education classes at a nominal charge to members and non-members. These are the kinds of benefits the Clinton plan would provide for all Americans, and I applaud that. However, prevention cannot simply be added on to current medical practice. Instead, we believe that it must be redefined to include all aspects of medical practice.

At Harvard Community Health Plan, our goal is to make prevention synonymous with medical practice - to manage the health of our members through their entire lives and to manage their care through the course of any disease or medical condition. HCHP's Principles of Medical Quality are based on prevention; they state, "We endeavor to give care that will make a real difference in keeping people healthy or restoring their health; the delivery of such care is our highest priority."

The practice of preventive medicine is not limited, in our view, to the traditional emphasis on those things one doctor can do with one patient. Instead, prevention must involve

individual providers, groups of providers, and organized networks. And prevention must be based on continously refined programs that have far-reaching, measurable benefits for all or part of a population.

Prevention is a clinical process, or series of processes, just like the rest of medicine. The processes of prevention must be organized, measured, subjected to standards of effectiveness and appropriateness, and continuously improved upon. In this context, prevention includes assessment of patient risk factors, behavior modification, health screening, education and counseling, outreach, clinical quality improvement, coordination of medical services, and integration with social services outside of the medical setting.

Specifically, in HCHP's preventive practice, we seek to manage, on behalf of our members:

- Primary prevention, which includes immunization against preventable diseases, risk assessment and behavior modification to reduce health risks. The Preventative Services Task Force states that "The most promising role for prevention in current medical practice may lie in changing the personal health behaviors of patients long before clinical disease develops... conventional clinical activities may be of less value to patients than activities once considered outside the traditional role of the clinician."

- Secondary prevention, which includes outreach to patients, the early detection of disease through appropriate screening, and the use of clinical guidelines for the management of conditions before they become serious. Prevention can begin before birth, even before conception. Timely detection of problems often makes more effective treatment possible and almost always improves planning for future management of illness or other conditions.

- Informed treatment of illness, which includes understanding the factors that make care and treatment difficult, and applying coordination of care, teamwork and problem-solving to improve outcomes, quality-of-life and value in a measurable way.

- And the wise use of resources, which means avoiding unnecessary or ineffective care that in many cases can do more harm than good. At the same time, it means basing clinical decisions on clinical and scientific assessment and never on cost alone.

As in all areas of medical practice, there is much less certainty than one might hope for or assume about which preventive practices work and which are most cost-effective. For instance, it was once believed that the annual physical exam was good preventive care; today the focus is on appropriate health screenings at appropriate times in one's life, not only to prevent unnecessary cost, but to improve quality of care.

Reaching a consensus on what comprises good preventive practice is not easy. There is much work being done through expert panels and research projects on developing consensus, and our understanding of what is useful prevention is constantly evolving. At HCHP we try to base our preventive interventions on those practices where a consensus has been achieved. In addition, we seek to continuously monitor and update the latest knowledge and build consensus within our own group through communication and team-building.

Let me outline a few specific examples of what HCHP is doing to integrate prevention into our practice of medicine.

As I mentioned earlier, we provide and cover a wide variety of primary and secondary preventive measures and we try to encourage and teach healthy behaviors to our members. Each new member now receives a brochure ("Staying Healthy") that contains our recommendations for immunizations and screening tests for men, women and children at various ages. We support compliance with our screening recommendations in a number of ways, including computer-generated reminders that are produced at patient visits, and through programs such as our flu shot program for high-risk members. As the attached "report card" shows, we measure our performance on a regular basis and we use clinical quality improvement techniques to help us increase compliance and follow-up. A striking example of success in clinical quality improvement is documented on another attachment,

which shows that follow-up or notification within 6 to 9 months of an abnormal pap smear is now at the 99 percent level at HCHP, compared with typical benchmark data of 70 percent.

In the managed treatment of illness, I would point to the example of HCHP's central AIDS program. Our AIDS program enables a large number of primary care providers with varying levels of experience with HIV infection to provide up-to-date management of their patients' problems by having a central clinical resource available 24 hours a day, along with ongoing educational programs. Our patients feel supported by having a sympathetic and knowledgeable nurse who provides education, emotional support and help in assessing clinical trials, and who facilitates appropriate and timely care for acute problems. Since the inception of the program, we find that potentially serious illnesses are diagnosed earlier, decreasing hospitalization and maximizing use of at-home therapies, which leads to shortened length of hospital stays as indicated on the attached graph.

And finally, how do we prevent the unnecessary use of resources? Several years ago a team began looking at the use of cranial imaging -- MRIs and CT scans of the head -- as a diagnostic tool for headaches. Information on cranial imaging use in internal medicine and pediatric departments was compiled and distributed to primary care physicians along with medical literature on the use of cranial imaging for headache disorders. Consultation with staff neurologists was encouraged. The result, shown on the attached chart, has been a significant decrease in cranial imaging utilization, without any reduction in quality of care.

HCHP's preventive care is delivered primarily to an enrolled population through prepaid group practice. As an HMO, we aren't faced with many of the barriers, mentioned earlier, that stand between the patient or the provider and the practice of prevention. At the same time, managed group practice allows for a complex interplay between the care of a population and the care of an individual. The care of a population involves probability, statistics, systems of care, and the careful measurement of the outcomes of care. The care of an individual requires weaving the probability characteristics of a population into the meaningful care of a single person at a single point in time. For our group practice, this

means crafting the teamwork, collaboration, innovation and various viewpoints of the group members into single acts of care between a provider and patient.

It is important to acknowledge that even with universal coverage for preventive care, an increase in primary care providers, and even a restructuring of our health-care system over time into one that is less fragmented and more coordinated, there is no guarantee that a strategy of prevention will be successful. Health care is only a small part of most people's lives. In order to be effective, prevention must be delivered and communicated forcefully and consistently in many other settings -- at home, in schools, in places of employment, in prisons, in community organizations and agencies of all kinds. And we as a nation must deal with the many social and economic issues that stand in the way of effective prevention -- poverty, homelessness, illiteracy and lack of transportation to name a few.

Ultimately, our goal must be to make health care a much smaller part of people's lives, in terms of incidents of illness, disfunction, cost and administrative hassle. An effective national strategy of prevention, based on clear goals and standards, coordinated processes of care and necessary follow-up, measurement of performance, and continuous improvement, all supported by adequate funding, will all contribute to our meeting that goal.

MDO
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Harvard Community Health Plan
Health Screening For Adults: Report Card

MEASURES:	Comparative Results		
	HCHP*	Best HMO Practice	Healthy People 2000**
Routine Screening Visit	69.0%	NA	NA
Blood pressure	87.6%	94.8%^	90.0%
Cholesterol	87.6%	64.0%^^	75.0%
Pelvic exam	64.5%	NA	NA
Stool Blood	58.2%	NA	50.0%
Mammography: Annual	56.7%	59.6%^^^	NA
Biannual	77.5%	80.0%^^^^	NA
Manual exam & Clinical Breast Exam: Annual	46.8%	NA	NA
Biannual	71.5%	NA	60.0%
Pap Smear: Annual	52.4%	59.0%^^^^	NA
Biannual	70.3%	87.0%^^^^^	85.0%

Footnotes:

It has been difficult to find comparable measurements of the same indicator in multiple organizations prior to HEDIS 2.0.

*HCHP Adult Screening Measurement: Ages 52-64 years, continuously enrolled during 1991 and 1992 with at least one visit or test in the previous 2 years, except for cholesterol which was within the previous 5 years. Stool blood test results were from either FOBT cards returned by patients or guaiac result from a rectal exam. The mammography and clinical breast exam rate was calculated for members who had a mammography and a routine screening visit. It was assumed that a clinical breast exam was performed at a routine screening visit.

**Healthy People 2000: Goals for the Nation:

a) Increase to at least 90% the proportion of adults who have had their blood pressure measured within the preceding 2 years and can state whether their blood pressure was normal or high.

b) Increase to at least 75% the proportion of adults who have had their blood cholesterol checked within the preceding 5 years.

c) Increase to at least 50% the proportion of people aged 50 and older who have received FOBT (stool blood test performed either by patient or medical personnel) within the preceding 1 to 2 years.

d) Increase to at least 60% the proportion of women aged 50 and older who have received a clinical breast examination and mammogram within the preceding 1 to 2 years.

e) Increase to at least 85% the proportion of women aged 18 and older with uterine cervix who have received a Pap test within the preceding 1 to 3 years.

^BP screening rate for adults who had a BP measured and recorded within the last 3 years.

^^Cholesterol rate, adults > 42 years who had a cholesterol test (either cholesterol or cholesterol ratio) during the past 4 years (1988-1991) and who were continuously enrolled at least 2 of those 4 years.

^^^("Best Practice"; not corporation averages) Mammography in 1992 women ages 50-75 years who were continuous members during 1992.

^^^^1989 survey of women ages 50-74, percent received a mammogram within the past 2 years.

^^^^^Pap smear rate, women =>18 years who were continuously enrolled during 1991 and had a Pap smear.

^^^^^1991 survey of women ages 40-64 years, percent received a Pap smear in the last 2 years.

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Harvard Community Health Plan
Summary: Abnormal Pap Smear Follow-up

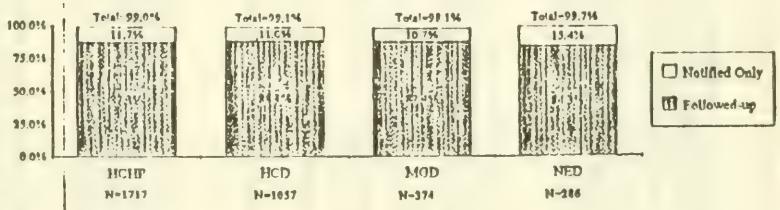
Purpose: To determine the rates of follow-up and notification for women who had an abnormal Pap smear.
Methodology: All abnormal Pap smears performed during July - September 1992 were identified from the various lab systems. Follow-up information was collected from the lab systems, claims data, and medical record review. *Follow-up* was defined as a repeat Pap smear, colposcopy, or surgery. *Notification* was defined as an attempt to notify the patient of the abnormal result. The *study period* for data collection was July 1992 - March 1993.

Key Findings

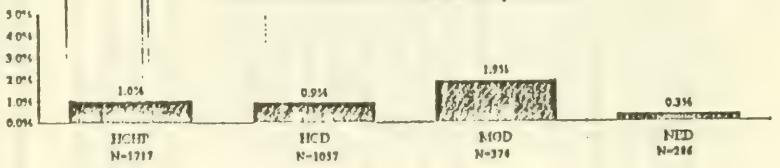
Success in achieving follow-up for abnormal Pap smears is exceedingly high in all three divisions, particularly when compared to benchmark data. Benchmark data available from published studies in a variety of clinical settings indicate a typical follow-up rate of 70%. The best follow-up rate achieved in any published report is 95% at one year. Previous HCHP studies indicate follow-up/notification rates of 99.2% in the HCD and 100.0% in the NED (follow-up/notification to occur within one year). No previous MOD data are available.

Results

Follow-up or Notification without Follow-up within 6-9 Months of Abnormal Pap Smear



No Evidence of Follow-up or Notification within 6-9 Months of Abnormal Pap Smear



There are no significant differences between divisional rates ($p<.05$).

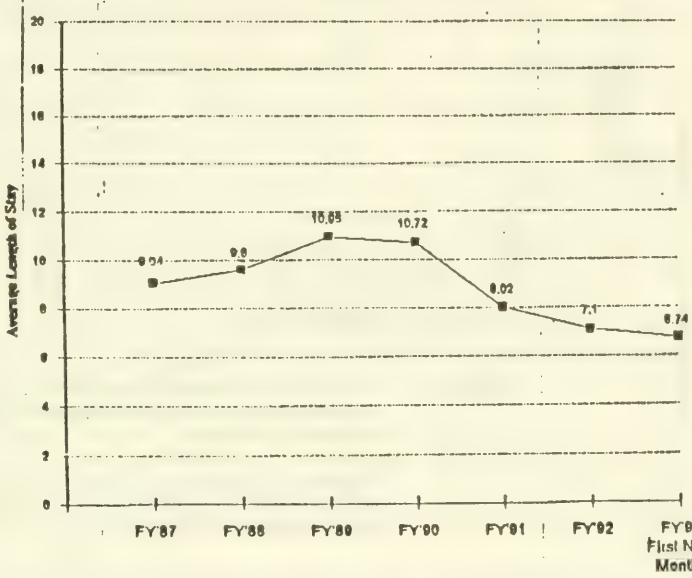
Team Members/Contributors: Debra Cookson & James Zazzali, co-leaders, Brian Chung, Lisa Feingold, MSPH, Larry Gottlieb, MD, Pam Liney, MA, Suzanne Payne McGuirk, MBA, Stephen Schoenbaum, MD, Dorlene Smith, Jean Thomas, NP.
For more information, please contact James Zazzali at (617) 731-7533 or x87533. Report Date: September 1993.

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Medical Director's Office

Harvard Community Health Plan
HCD Central AIDS Program

Significance: The HCHP Central AIDS Program provides a wide range of hospital, ambulatory, and homecare services for members with HIV, ARC, and AIDS. The goal of the program is to provide coordinated and comprehensive care through a team of medical and nurse specialists, aimed at supporting affected members' complex routine and emergency medical, social, psychological, and educational needs.

Central AIDS Program Inpatient Discharge Summary



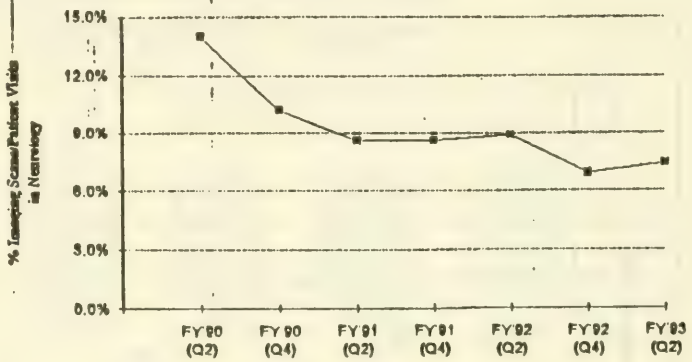
Action for Improvement: Ongoing tracking system of services provided for and status of members with HIV, ARC, and AIDS

MDO
Medical Director's Office

Harvard Community Health Plan
Analysis of Use of MRI's and CT Scans of the Head

Significance: The use of expensive diagnostic tests does not always result in improved health outcomes for our members. In an effort to understand cranial imaging utilization, the Neurology Department has tracked and reviewed utilization over the past three years.

Cranial Imaging Utilization *



* Measurements were conducted twice yearly

Results:

- Information on cranial imaging utilization for departments of Internal medicine and pediatrics was compiled and distributed to primary care clinicians.
- Clinicians were offered medical literature concerning cranial imaging for headache disorders and reinforcement that Neurologists are available for consultation.

Action for Improvement: Stable levels have been achieved as of FY'90 (Q2). Plans are to continue tracking individual and comparative data.

The CHAIRMAN. Dr. Henley.

Dr. HENLEY. Thank you, Mr. Chairman.

I would ask that our written comments of the Academy be placed into the record.

The CHAIRMAN. They will be.

Dr. HENLEY. My name is Douglas Henley, and I am here today as a member of the board of directors of the American Academy of Family Physicians; but I would indicate to you that I am also a family doctor in rural North Carolina, practicing with my four partners and three physician's assistants that we employ, providing comprehensive medical care to over 25,000 patients in our area.

On behalf of our 74,000 members at the Academy, I am pleased to discuss with you the important issue of coverage for clinical preventive services in the President's health care reform proposal.

Let me first indicate that the Academy is extremely supportive of the President's principles of health care reform and many of its strategies. But we are especially excited and encouraged and supportive of the emphasis being placed by the President on clinical preventive services and their coverage. Family physicians are uniquely trained to provide these services regardless of the patient's age or gender.

We have long advocated the need to provide for age-appropriate and effective clinical preventive services. Those services identified in the President's proposal are essentially the same as those which exist in our health care reform proposal, "Rx for Health." They would cover all age groups and are consistent with the recommendation of the U.S. Preventive Services Task Force.

In the President's plan, we finally have an approach that is truly comprehensive, that places strong emphasis once and for all on preventive services, while at the same time providing coverage for routine medical care.

If I may, I would like to summarize three particular points regarding our concerns on these issues. The first deals with the methodology of determining which preventive services should be covered in the President's plan. We believe this is a very important scientific issue.

Some preventive services, such as prenatal care and immunizations, have been well documented to reduce both individual and societal costs. Where those exist and the data exist, they should be covered, without deductibles or copayments or coinsurance.

But other services, even some that are highly promoted, have very limited or no documentation regarding positive outcomes. We would highly recommend that the work of such experts as Dr. David Eddy and the Preventive Services Task Force be utilized by your committee as a resource to determine those preventive services to be ultimately included in the basic benefits package.

These experts advocate and utilize, as has the Academy, an explicit method for making clinical policy recommendations. This is a very rigorous and outcomes-based approach and one that the Academy has used since 1990 in developing our age charts for periodic health intervention, which are updated annually and are appended to our written testimony that I would bring to your attention.

As you debate this important issue of coverage, the methodology of determining coverage must be addressed. We would ask that you require two things. First, insist on an explicit method and an outcomes-based approach to be utilized to establish and update these services. The old-style consensus approach must be thrown out. We cannot afford to pay for services simply because they seem right or because they relate to the most current fad disease in the eye of the public or the media.

Second, establish a single entity empowered to make the final recommendations for covered clinical preventive services, based upon the methodology that I have outlined. Multiple guidelines from multiple groups are confusing to physicians and patients. A single entity to approve such covered services will eliminate this confusion.

The second issue that relates to the first deals with the issue of funding. We would suggest that the research necessary to develop this methodology and to determine which services should be covered, based upon first dollar amounts, is clearly within the domain of primary care research.

I urge caution in how you utilize increased Federal funding to accomplish this research. We would strongly urge that such research occur through the Agency for Health Care Policy and Research; caution in the sense that through the National Institutes of Health, primary care research is perhaps not the right domain.

Finally, I would like to emphasize the important issue of the periodic health exam. The President's proposal for clinical preventive services includes such age-appropriate examinations. The time necessary for these visits, however, is dealt with primarily as a routine office visit and frequently focuses on just simply tests and procedures. If we are truly to put prevention into practice, we must shift the focus of such visits to the necessary counseling, screening, and risk factor reduction that is necessary for these very, very important visits. They are anything but routine, and they require greater expertise and time and skill on the part of the physician.

I strongly encourage you to place more attention on the physician/patient interaction rather than on the tests that may be ordered. Unique CPT codes exist for these services and should be reimbursed to reflect the time and skill required in carrying out a comprehensive history, a comprehensive exam, risk assessment and counseling.

In summary, Mr. Chairman, we applaud the President's strong emphasis on clinical preventive services. Clarification about which services to be covered is very important, and we provide our information for your use.

The Academy stands ready to assist this Congress and the President as these issues are debated. I thank you for your time and would be happy to respond to your questions.

The CHAIRMAN. Thank you very much.

[The prepared statement of Dr. Henley follows:]

PREPARED STATEMENT OF DR. DOUGLAS E. HENLEY

My name is Douglas E. Henley M.D. I am a member of the Board of Directors of the American Academy of Family Physicians, and I am privileged to serve as chair of the Academy's Commission on Public Health and Scientific Affairs. On behalf of the Academy's 74,000 members, I am pleased to appear before the Committee

this morning to discuss coverage of clinical preventive services in President Clinton's health system reform proposal.

The Academy is encouraged and excited by the emphasis on clinical preventive services in the President's program for health care reform. Family physicians are uniquely trained to provide these services, but we and our patients have been frustrated that such services have not been covered by existing insurance plans.

The Academy has long supported the need to provide age-appropriate and effective clinical preventive services. Those services identified in the President's program are essentially the same as those included in our health care reform plan, Rx for Health. In the President's plan, we finally have an approach that is comprehensive—one which includes preventive services as well as medical care services. In so doing, the President's proposal agrees with our philosophy and approach to comprehensive, cost-effective primary care.

Preventive services in the President's proposal cover all age groups and are consistent with the recommendations of the U.S. Preventive Services Task Force (USPSTF). The Academy has actively participated in the deliberations of the Task Force and applauds its outcomes-based method for in determining the effectiveness of specific clinical preventive services.

We have also worked with the National Coordinating Committee on Clinical Preventive Services (NCCCPS) and the Office of Disease Prevention and Health Promotion (ODPHP) to integrate clinical preventive services into the practices of our 74,000 members. We are, in fact, very excited to have just received funding from the Department of Health and Human Services to implement their "Put Prevention into Practice" campaign.

Some specific issues I would like to discuss with you today are the costs of clinical preventive services, the scientific methods for recommending coverage of specific clinical preventive services, the critical importance of protecting physicians who follow the recommended protocols, the importance of emphasizing the periodic health exam, and a major concern we have about coverage of clinical preventive services in the Medicare Program.

Costs of clinical preventive services

Working with data collected by the NCCCPS, we have learned that including preventive services into the existing system would increase total premiums in the average employer's health plan by only three percent or less. While we acknowledge these costs to be real, we believe strongly that great savings would ultimately result from this important investment. These savings come from the prevention of disease, diagnosing disease early and thereby effecting early cure or control, allowing for less expensive interventions, reducing the physical and emotional burden associated with an illness, and allowing affected individuals to be more productive in our society.

Methods for recommending coverage

Careful consideration must be given, now and in the future, to those clinical preventive services identified for coverage in the proposed benefits package. Some services, such as prenatal care and immunizations, have been well documented to reduce both individual and societal costs. These should be included without requiring deductibles, copayments or coinsurance. Other frequently recommended clinical preventive services do not have clearly established beneficial outcomes, and there are few useful studies showing they are worth the cost. Some services, even some that are highly promoted, have very limited or no documentation of positive benefit in relation to the high associated costs.

I would highly recommend the work of such experts as Dr. David Eddy and the USPSTF be used as resources as you in determine those clinical prevention services to be ultimately included in a basic benefits package with no cost-sharing.

For the past 6 years, the Academy has used an explicit method for making clinical policy recommendations. The method is outcomes-based and considers both the harm and benefit to the patient. This rigorous, evidenced-based method is also utilized by the Agency for Health Care Policy and Research (AHCPR) and the Centers for Disease Control (CDC). It is not being used, as yet, by the NIH!

Since 1990, the Academy has published its Age Charts for Periodic Health Intervention, which are updated annually using this approach. These charts are appended to the written testimony distributed to each of you.

As you debate this important issue of coverage for clinical preventive services, we urge you to require two things:

(1) Insist that an explicit method and outcomes-based approach be utilized to establish and update these services. The "old style" consensus approach must be thrown out. We cannot afford to pay for such services simply because they

"seem" right or relate to the most current "fad" disease in the eye of the public or the media.

(2) Establish a single entity empowered to make the final recommendations for covered clinical preventive services based upon the method described above. Multiple guidelines or clinical policies from multiple groups or organizations are confusing to physicians and patients. A single entity to approve the covered services will alleviate much of this confusion.

Presumptive defense

The third issue I wish to address is the protection of physicians who follow the recommended protocol for clinical preventive services. It is critical that such a liability shield be legislatively mandated for when a physician's practice is based on such a protocol. The current inconsistency of the multiple sets of guidelines including such services as mammography and prostate cancer screening continue to leave the physician open to litigation. Without a liability shield, the need to protect oneself will continue to motivate the inappropriate use of tests and procedures.

Periodic health exams

The President's proposal for clinical preventive services includes age-appropriate periodic health exams. The time necessary for such a visit, however, is dealt with as a "routine office visit" and focuses on tests and procedures. If we are truly to put prevention into practice, we must shift the focus of such visits to the counseling, screening and risk factor reduction that occurs during these important visits. They are anything but routine and require greater expertise and skill on the part of the physician. I strongly encourage you to place more attention on the physician-patient interaction than on the test that may be ordered. Unique Current Procedural Terminology (CPT) codes exist for these services and should be reimbursed to reflect the time and skill required in carrying out a comprehensive history, exam, risk assessment and patient counseling.

Coverage under Medicare

This brings me to a major concern of the Academy about coverage of these periodic health exams under the Medicare Program. While we strongly support such coverage, we ask you not to do so at the expense of other primary care services. The current process for updating the Medicare physician fee schedule does not protect primary care services in a manner afforded by Medicare Volume Performance Standard. It is, therefore, critical that coverage of these periodic health exams not reduce payment for other equally important primary care services.

In summary, we applaud the President's strong emphasis on the provision of clinical preventive services as a part of health care reform. Clarification about the preventive services to be covered is important, and we provide our guidelines as one resource. The Academy stands ready to assist Congress and the President as these issues are debated. I thank you for the opportunity to appear before you today and will be pleased to respond to any questions.

AMERICAN ACADEMY OF FAMILY PHYSICIANS

AGE CHARTS FOR PERIODIC HEALTH EXAMINATION

510—Preamble, 510A—Ages Birth-18 Months, 510B—Ages 19 Months-6 Years, 510C—Ages 7-12 Years, 510D—Ages 13-18 Years, 510E—Ages 19-39 Years, 510F—Ages 40-64 Years, 510G—Ages 65 Years and Older

These recommendations are provided only as an assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations.

PREAMBLE TO AGE CHARTS FOR PERIODIC HEALTH EXAMINATION

Periodic health examination, including immunizations, counseling, and other preventive services, are a part of continuing, comprehensive care in family practice. The content and frequency of these health examinations should be tailored to the patient's age, sex, and risk factors. Delivery of clinical preventive services should not be limited only to visits for health maintenance but also should be provided as a part of visits for other reasons such as acute and chronic care. For many patients, these visits provide the only opportunity to receive preventive services.

The following age-specific charts for periodic health examination are recommended by the Subcommittee on Periodic Health Intervention of the Commission on Public Health and Scientific Affairs as the minimum clinical preventive services to be provided for asymptomatic patients. They are based on the Guide to Clinical Preventive Services: Report of the U.S. Preventive Services Task Force, the American College of Physicians outcomes-based recommendations on hormone replacement therapy and recommendations of the Commission on Public Health and Scientific Affairs. In making these recommendations, the subcommittee notes:

A) That all patients new to a medical practice should be urged to receive a comprehensive history and physical as well as the screening, laboratory and diagnostic procedures, counseling, immunizations and chemoprophylaxis appropriate for the patient's age, sex, and risk. Subsequent visits may be used in completion of workup.

B) That former health records should be obtained for review and avoidance of duplications of laboratory testing.

C) That the charts are not exhaustive and that physicians may add other preventive services either routinely or for individual patients based on clinical judgment.

D) That as new scientific findings become available, the subcommittee anticipates changes in the recommendations.

E) That the subcommittee has added interventions beyond the recommendations of the U.S. Preventive Services Task Force and other explicitly developed guidelines that it feels are necessary. These are noted with footnotes on the charts and shown in italics.

F) The date in the lower right hand comer identifies the most recent update of these charts. The date in the lower left hand comer is the most recent printing. This document is updated annually.

American Academy of Family Physicians

Periodic Health Examination*

Ages: 65 Years and Over

Schedule: Every Year[1]

(See Preamble)

Screening

History

Interval medical and family history[1]
Medication use (prescription and non-prescription)
Prior symptoms of transient ischemic attack
Dietary intake
Physical activity
Tobacco/alcohol/drug use
Functional status at home

[1]An update of the previously obtained medical and family medical history is recommended by the subcommittee.

Physical Examination

Height and weight
Blood pressure[2]
Visual acuity
Hearing and hearing aids
Clinical breast exam[3]
Pelvic exam
Cardiac auscultation
Digital rectal exam[4]

High Risk Groups

Auscultation for carotid bruits (HR1)
Complete skin exam (HR2)
Complete oral cavity exam (HR3)
Palpation of thyroid nodules (HR4)

[1]At every physician visit with a minimum of every two years.
[2]Annually.
[3]The subcommittee recommends this procedure but recognizes the scientific evidence supporting it may not be conclusive.

Laboratory/Diagnostic Procedures

Nonfasting *or fasting*[1] total blood cholesterol
Dipstick urinalysis
Mammogram[2]
Thyroid function tests[3]

High Risk Groups

Fasting plasma glucose (HR5)
Tuberculin skin test (PPD) (HR6)
Electrocardiogram (HR7)
Papanicolaou smear[4] (HR8)
Fecal occult blood/sigmoidoscopy (HR9)
Fecal occult blood/colonoscopy (HR10)

[1]At least every five years.
[2]It is recommended that mammography be performed annually for all women beginning at age 50.
[3]For women.
[4]Every 1–3 years.

Counseling

Diet and Exercise

Fat (especially saturated fat), cholesterol, complex carbohydrates, fiber, sodium, calcium[1]
Nutritional assessment
Selection of exercise program

[1]For women.

Substance Use

Tobacco cessation
Alcohol and other drugs:
Limiting alcohol consumption
Driving/other dangerous activities while under the influence
Treatment for abuse

Sexual Practices

Sexuality

Injury Prevention

Prevention of falls
Safety belts
Smoke detector
Smoking near bedding or upholstery
Hot water heater temperature (≤ 120 F)
Safety helmets

High Risk Groups

Prevention of childhood injuries (HR12)

Dental Health

Regular tooth brushing, flossing, dental visits

Other Primary Preventive Measures

Glaucoma testing
Advance directives/living will/durable power of attorney
Discussion of hormone replacement therapy in women

High-Risk Groups

Discussion of aspirin therapy (HR13)
Skin protection from ultraviolet light (HR14)

Immunizations and Chemoprophylaxis

Tetanus diphtheria (Td) booster[10]
Influenza vaccine[11]
Pneumococcal vaccine
  High Risk Groups
Hepatitis B vaccine (HR15)

[10]Every 10 years
[11]Annually

Additional Notes

Leading Causes of Death:
- Heart disease
- Cerebrovascular disease
- Obstructive lung disease
- Pneumonia/influenza
- Lung cancer
- Colorectal cancer

Remain Alert For:
- Depression symptoms
- Suicide risk factors (HR11)
- Abnormal bereavement
- Changes in cognitive function
- Medications that increase risk of falls
- Signs of physical abuse or neglect
- Malignant skin lesions
- Peripheral arterial disease
- Tooth decay, gingivitis, loose teeth

(High-Risk Categories listed on following page.)

*This list of preventive services is not exhaustive. It reflects only those topics reviewed by the U.S. Preventive Services Task Force *and the AAFP Conference on Public Health and Screening Tests*. Clinicians may wish to add other preventive services on a routine basis and after considering the patient's medical history and other individual circumstances. Examples of target conditions not specifically examined by the Task Force include:

- Chronic obstructive pulmonary disease
- Hepatobiliary disease
- Bladder cancer
- Endometrial disease
- Travel related illness
- Prescription drug abuse
- Occupational illness and injuries

†The recommended schedule applies only to the periodic visit itself. The frequency of the individual preventive services listed in this table is left to clinical discretion, except as indicated in other footnotes.

High-Risk Categories

HR1 Persons with risk factors for cerebrovascular or cardiovascular disease (e.g., hypertension, smoking, CAD, atrial fibrillation, diabetes) or those with neurologic symptoms (e.g., transient ischemic attacks) or a history of cerebrovascular disease.

HR2 Persons with a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions (e.g., dysplastic nevi, certain congenital nevi).

HR3 Persons with exposure to tobacco or excessive amounts of alcohol, or those with suspicious symptoms or lesions detected through self-examination.

HR4 Persons with a history of upper body irradiation.

HR5 The markedly obese, persons with a family history of diabetes, or women with a history of gestational diabetes.

HR6 Household members of persons with tuberculosis or others at risk for close contact with the disease (e.g., staff of tuberculosis clinics, shelters for the homeless, nursing homes, substance abuse treatment facilities, dialysis units, correctional institutions), recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific Islands), migrant workers; residents of nursing homes, correctional institutions, or homeless shelters; or persons with certain underlying medical disorders (e.g., HIV infection).

HR7 Men with two or more cardiac risk factors (high blood cholesterol, hypertension, cigarette smoking, diabetes mellitus, family history of CAD); men who would endanger public safety were they to experience sudden cardiac events (e.g., commercial airline pilots); or sedentary or high-risk males planning to begin a vigorous exercise program.

HR8 Women who have not had previous documented screening in which smears have been consistently negative.

HR9 Persons who have first degree relatives with colorectal cancer; a personal history of endometrial, ovarian, or breast cancer; or a previous diagnosis of inflammatory bowel disease, adenomatous polyps, or colorectal cancer.

HR10 Persons with a family history of familial polyposis coli or cancer family syndrome.

HR11 Recent divorce, separation, unemployment, depression, alcohol or other drug abuse, serious medical illnesses, living alone, or recent bereavement.

HR12 Persons with children in the home or automobile.

HR13 Men who have risk factors for myocardial infarction (e.g., high blood cholesterol, smoking, diabetes mellitus, family history of early-onset CAD) and who lack a history of gastrointestinal or other bleeding problems, and other risk factors for bleeding or cerebral hemorrhage.

HR14 Persons with increased exposure to sunlight.

HR15 Homosexually *and bisexually* active men, intravenous drug users, recipients of some blood products, persons in health related jobs with frequent exposure to blood or blood products, *household and sexual contacts of HBV carriers, sexually active heterosexual persons with multiple sexual partners diagnosed as having recently acquired sexually transmitted disease, prostitutes, and persons who have a history of sexual activity with multiple partners in the previous six months*

Ages: 40-64 Years

High-Risk Categories

HR1 Persons with a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions (e.g., dysplastic nevi, certain congenital nevi).

HR2 Persons with exposure to tobacco or excessive amounts of alcohol, or those with suspicious symptoms or lesions detected through self-examination.

HR3 Persons with a history of upper body irradiation.

HR4 Persons with risk factors for cerebrovascular or cardiovascular disease (e.g., hypertension, smoking, CAD, atrial fibrillation, diabetes) or those with neurologic symptoms (e.g., transient ischemic attacks) or a history of cerebrovascular disease.

HR5 The markedly obese, persons with a family history of diabetes, or women with a history of gestational diabetes.

HR6 Prostitutes, persons who engage in sex with multiple partners in areas in which syphilis is prevalent, or contacts of persons with active syphilis.

HR7 Persons with diabetes.

HR8 Persons who attend clinics for sexually transmitted diseases, *attend other high-risk health care facilities (e.g., adolescent and family planning clinics), or have other risk factors for chlamydial infection (e.g., multiple sexual partners or a sexual partner with multiple sexual contacts).*

HR9 Prostitutes, persons with multiple sexual partners or a sexual partner with multiple contacts, sexual contacts of persons with culture-proven gonorrhea, or persons with a history of repeated episodes of gonorrhea.

HR10 Persons seeking treatment for sexually transmitted diseases; homosexual and bisexual men; past or present intravenous (IV) drug users; persons with a history of prostitution or multiple sexual partners; women whose past or present sexual partners were HIV infected, bisexual, or IV drug users; persons with long-term residence or birth in an area with high prevalence of HIV infection; or persons with a history of transfusion between 1978 and 1985.

HR11 Household members of persons with tuberculosis or others at risk for close contact with the disease (e.g., staff of tuberculosis clinics, shelters for the homeless, nursing homes, substance abuse treatment facilities, dialysis units, correctional institutions); recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific Islands); migrant workers; residents of nursing homes, correctional institutions, or homeless shelters; or persons with certain underlying medical disorders (e.g., HIV infection).

HR12 Persons exposed regularly to excessive noise.

HR13 Men with two or more cardiac risk factors (high blood cholesterol, hypertension, cigarette smoking, diabetes mellitus, family history of CAD); men who would endanger public safety were they to experience sudden cardiac events (e.g., commercial airline pilots); or sedentary or high-risk males planning to begin a vigorous exercise program.

HR14 Persons aged 50 and older who have first-degree relatives with colorectal cancer; a personal history of endometrial, ovarian, or breast cancer, or a previous diagnosis of inflammatory bowel disease, adenomatous polyps, or colorectal cancer.

HR15 Persons with a family history of familial polyposis coli or cancer family syndrome.

HR16 Perimenopausal women at increased risk for osteoporosis (e.g., Caucasian race, bilateral oophorectomy before menopause, slender build) and for whom estrogen replacement therapy would otherwise not be recommended.

HR17 Recent divorce, separation, unemployment, depression, alcohol or other drug abuse, serious medical illnesses, living alone, or recent bereavement.

HR18 Persons over age 50, smokers, or persons with diabetes mellitus.

HR19 Intravenous drug users.

HR20 Persons at increased risk for low back injury because of past history, body configuration, or type of activities.

HR21 Persons with children in the home or automobile.

HR22 Persons with older adults in the home.

HR23 Persons with increased exposure to sunlight.

HR24 Men who have risk factors for myocardial infarction (e.g., high blood cholesterol, smoking, diabetes mellitus, family history of early-onset CAD) and who lack a history of gastrointestinal or other bleeding problems, and other risk factors for bleeding or cerebral hemorrhage.

HR25 Homosexually *and bisexually* active men, intravenous drug users, recipients of some blood products, persons in health-related jobs with frequent exposure to blood or blood products, *household and sexual contacts of HBV carriers, sexually active heterosexual persons with multiple sexual partners diagnosed as having recently acquired sexually transmitted disease, prostitutes, and persons who have a history of sexual activity with multiple partners in the previous six months.*

HR26 Persons with medical conditions that increase the risk of pneumococcal infection (e.g., chronic cardiac or pulmonary disease, sickle cell disease, nephrotic syndrome, Hodgkin's disease, asplenia, diabetes mellitus, alcoholism, cirrhosis, multiple myeloma, renal disease or conditions associated with immunosuppression).

HR27 Residents of chronic care facilities and persons suffering from chronic cardiopulmonary disorders, metabolic diseases (including diabetes mellitus), hemoglobinopathies, immunosuppression, or renal dysfunction.

American Academy of Family Physicians

Periodic Health Examination
Birth to 18 Months

Schedule: 2, 4, 6, *(12)*, 15, 18 Months[1]
(See Preamble)

First Week

Ophthalmic antibiotics[1]
Hemoglobin electrophoresis (HR4)[1]
14/15H[2]
Phenylalanine[2]
Hearing (HR1)

[1]At birth
[2]Days 3 to 6 preferred for testing

Screening

History	Physical Examination	Laboratory/Diagnostic Procedures
Interval medical and family history[1]	Height and weight	Hemoglobin and/*or* hematocrit[4] High-Risk Groups Hearing[3] (HP1) *Whole blood lead* (HR2)
[1]*An updating of the previously obtained medical and family medical history is recommended by the subcommittee.*		[3]Once during infancy. *The subcommittee believes either test is acceptable.* [3]By age 18 months, if not tested earlier.

Parent Counseling

Diet and Exercise	Substance Use	Sexual
Breastfeeding Nutrient intake, especially iron-rich foods		
Injury Prevention	**Dental Health**	**Other Primary Preventive Measures**
Child safety seats Smoke detector Hot water heater temperature (≤ 120 F) Stairway gates, window guards, pool fence Storage of drugs and toxic chemicals Syrup of ipecac, poison control telephone number	Baby bottle tooth decay	Effects of passive smoking *Assess risk of lead exposure* (HR2)

Immunizations and Chemoprophylaxis

Diphtheria-tetanus-pertussis (DTP) vaccine[4]
Oral poliovirus vaccine (OPV)[5]
Measles-mumps-rubella (MMR) vaccine[6]
Haemophilus influenzae type b (Hib) conjugate vaccine[6]
Hepatitis B vaccine (HBV)[7][8]
High-Risk Groups
Fluoride supplementation (HR3)
Influenza vaccine (HR5)

[4]At ages 2, 4, 6, and 15 *or 18* months. *Acellular pertussis vaccine may be used for the fourth and fifth doses.*
[5]Ages 2, 4, and 15 *or 18* months
[6]At age 15 months
[7]*If using HBOC, then at ages 2, 4, 6, and 15 months. If using PRP-OMP, then at ages 2, 4, and 12 months.*
[8]The recommended option for administration is birth (before discharge from hospital), 1–2 months, and 6–18 months. A second option is 1–2 months, 4 months and 6–18 months.

Additional Notes

Leading Causes of Death:	Conditions originating in perinatal period Congenital anomalies Heart disease Injuries (nonmotor vehicle) Pneumonia/influenza	Remain Alert For:	Ocular misalignment Tooth decay Signs of child abuse or neglect

High-Risk Categories

HR1 Infants with a family history of childhood hearing impairment or a personal history of congenital perinatal infection with herpes, syphilis, rubella, cytomegalovirus, or toxoplasmosis; malformations involving the head or neck (e.g., dysmorphic and syndromal abnormalities, cleft palate, abnormal pinna); birthweight below 1500 g; bacterial meningitis, hyperbilirubinemia requiring exchange transfusion; or severe perinatal asphyxia (Apgar scores of 0–3, absence of spontaneous respirations for 10 minutes, or hypotonia at 2 hours of age).

HR2 Infants who live in or frequently visit housing built before 1950 that is dilapidated or undergoing renovation; who come in contact with other children with known lead toxicity; who live near lead-processing plants or whose parents or household members work in a lead-related occupation; or who live near busy highways or hazardous waste sites. Does your child: a. Live in or regularly visit a house built before 1960? This could include a day care center, preschool, the home of a baby sitter or a relative, etc. b. Have a brother or sister, housemate, or playmate being followed or treated for lead poisoning (that is, blood lead ≥ 15 µg/dL)? c. Live with an adult whose job or hobby involves exposure to lead? d. Live near an active lead smelter, battery recycling plant, or other industry likely to release lead?

HR3 Infants living in areas with inadequate water fluoridation (less than 0.7 parts per million).

HR4 Newborns of Caribbean, Latin American, Asian, Mediterranean, or African descent.

HR5 Children over 6 months of age with chronic pulmonary or cardiovascular problems including asthma; or who required medical followup or hospitalization during the past year for chronic metabolic disease (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications).

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*This list of preventive services is not exhaustive. It reflects only those topics reviewed by the U.S. Preventive Services Task Force *and the AAFP Commission on Public Health and Scientific Affairs*. Clinicians may wish to add other preventive services on a routine basis and after considering the patient's medical history and other individual circumstances. Examples of target conditions not specifically examined by the Task Force include:

Developmental disorders	Metabolic disorders
Musculoskeletal malformations	Speech problems
Cardiac anomalies	Behavioral disorders
Genitourinary disorders	Parent/family dysfunction

†At least five visits are required for immunizations. Because of lack of data and differing patient risk profiles, the scheduling of additional visits and the frequency of the individual preventive services listed in this table are left to clinical discretion (except as indicated in other footnotes).

American Academy of Family Physicians

Periodic Health Examination*

Ages: 19 Months to 6 Years

Schedule: See Footnote[1]

(See Preamble)

Screening

History	*Physical Examination*[1]	Laboratory/Diagnostic Procedures
Interval medical and family history[1] *Developmental/behavioral assessment*	Height and weight Blood pressure Eye exam for amblyopia and strabismus[2]	Urinalysis for bacteriuria[3] High-Risk Groups *Whole blood lead* (HR1) Tuberculin skin test (PPD) (HR2) Hearing[2] (HR3)
[1]*An updating of the previously obtained medical and family medical history is recommended by the subcommittee*	[2]Ages 3-4	[3]*The optimal frequency for urine testing has not been determined and is left to clinical discretion. In general, dipsticks combining the leukocyte esterase and nitrite tests should be used to detect asymptomatic bacteriuria* [4]Annually [5]Before age 3, if not tested earlier

Patient & Parent Counseling

Diet and Exercise	Substance Use	Sexual
Sweets and between meal snacks, Iron enriched foods, sodium *Nutritional assessment* Selection of exercise program		*Initiate sex education*
Injury Prevention	**Dental Health**	**Other Primary Preventive Measures**
Safety belts Smoke detector Hot water heater temperature (≤ 120° F) *Burn protection* *Electrical cords and outlets* *Warning about strangers* Window guards and pool fence Bicycle safety helmets Storage of drugs, toxic chemicals, matches and firearms Syrup of Ipecac, poison control Telephone number	Tooth brushing Dental visits *starting at age 3*	Effects of passive smoking *Assess risk of lead exposure* (HR1) High-Risk Groups Skin protection from ultraviolet light (HR4)

Immunizations and Chemoprophylaxis

Diphtheria tetanus pertussis (DTP) vaccine[4]
Oral poliovirus vaccine (OPV)[4]
Measles-mumps rubella (MMR) vaccine[5]
Review Haemophilus influenzae type b (Hib) conjugate vaccine immunization status
Review hepatitis B vaccine (HBV) status
High-Risk Groups
Fluoride supplements (HR5)
Influenza vaccine (HR6)
Pneumococcal vaccine (HR7)

[4]Once between ages 4 and 6
[5]*Before school entry*

Additional Notes

Leading Causes of Death:	Injuries (nonmotor vehicle) Motor vehicle crashes Congenital anomalies Homicide Heart disease	Remain Alert For:	Vision disorders Dental decay, malalignment, premature loss of teeth, mouth breathing Signs of child abuse or neglect Abnormal bereavement

High-Risk Categories

HR1 Infants who live in or frequently visit housing built before 1950 that is dilapidated or undergoing renovation; who come in contact with other children with known lead toxicity; who live near lead-processing plants or whose parents or household members work in a lead-related occupation; or who live near busy highways or hazardous waste sites. Does your child: a. Live in or regularly visit a house built before 1960? This could include a day care center, preschool, the home of a baby sitter or a relative, etc. b. Have a brother or sister, housemate, or playmate being followed or treated for lead poisoning (that is, blood lead ≥ 15 µg/dL)? c. Live with an adult whose job or hobby involves exposure to lead? d. Live near an active lead smelter, battery recycling plant, or other industry likely to release lead?

HR2 Household members of persons with tuberculosis or others at risk for close contact with the disease; recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific Islands); family members of migrant workers; residents of homeless shelters; or persons with certain underlying medical disorders.

HR3 Children with a family history of childhood hearing impairment or a personal history of congenital perinatal infection with herpes, syphilis, rubella, cytomegalovirus, or toxoplasmosis; malformations involving the head or neck (e.g., dysmorphic and syndromal abnormalities, cleft palate, abnormal pinna); birthweight below 1500 g; bacterial meningitis; hyperbilirubinemia requiring exchange transfusion; or severe perinatal asphyxia (Apgar scores of 0-3, absence of spontaneous respirations for 10 minutes, or hypotonia at 2 hours of age).

HR4 Children with increased exposure to sunlight.

HR5 Children living in areas with inadequate water fluoridation (less than 0.7 parts per million).

HR6 Children with chronic pulmonary or cardiovascular problems including asthma; or who required medical follow-up or hospitalization during the past year for chronic metabolic disease (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications).

HR7 Children aged two and over with chronic illnesses specifically associated with pneumococcal disease or its complications, anatomic or functional asplenia, sickle cell disease, nephrotic syndrome or chronic renal failure, cerebrospinal fluid leaks, or conditions associated with immunosuppression (including HIV).

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*This list of preventive services is not exhaustive. It reflects only those topics reviewed by the U.S. Preventive Services Task Force *and the AAFP Commission on Public Health and Scientific Affairs*. Clinicians may wish to add other preventive services on a routine basis, and after considering the patient's medical history and other individual circumstances. Examples of target conditions not specifically examined by the Task Force include:

Developmental disorders
Speech problems
Behavioral and learning disorders
Parent/family dysfunction

†One visit is required for immunizations. Because of lack of data and differing patient risk profiles, the scheduling of additional visits and the frequency of the individual preventive services listed in this table are left to clinical discretion (except as indicated in other footnotes).

American Academy of Family Physicians

Periodic Health Examination*

Ages: 7-12 Years

Schedule: See Footnote[1]

(See Preamble)

Screening

History	*Physical Examination*[2]	Laboratory/Diagnostic Procedures
Interval medical and family history[1]	Height and weight Blood pressure *Tanner staging*[2]	High-Risk Groups *Total cholesterol*[3,5] *Lipoprotein analysis*[4,5] Tuberculin skin test (PPD) (HR1)
[1]*An updating of the previously obtained medical and family medical history is recommended by the subcommittee*	[2]*A physical examination including Tanner stage is recommended at least once in this age group by the subcommittee.*	[3]*Child of a parent with a blood cholesterol of 240mg/dL or higher* [4]*Child of a parent or grandparent with a documented history of premature (age less than 55 years) cardiovascular disease* [5]*The exact frequency is not determined. It should be performed at least once.*

Patient & Parent Counseling

Diet and Exercise	Substance Use	Sexual Practices
Fat (especially saturated fat), cholesterol, sweets and between meal snacks, sodium *Nutritional assessment* Selection of exercise program	*Tobacco, alcohol, and other drugs: primary prevention*	*Sex education*
Injury Prevention	**Dental Health**	**Other Primary Preventive Measures**
Safety belts Smoke detector Storage of firearms, drugs, toxic chemicals, matches Bicycle safety helmets	Regular tooth brushing and dental visits	High-Risk Groups Skin protection from ultraviolet light (HR2)

Immunizations and Chemoprophylaxis

Update of immunization status, including measles-mumps-rubella

High Risk Groups

Fluoride supplements (HR3)

Influenza vaccine (HR4)

Pneumococcal vaccine (HR5)

Additional Notes

Leading Causes of Death:	Motor vehicle crashes Injuries (nonmotor vehicle) Congenital anomalies Leukemia Homicide Heart disease	Remain Alert For:	Vision disorders Diminished hearing Dental decay, malalignment, mouth breathing Signs of child abuse or neglect Abnormal bereavement *Depressive symptoms*

High-Risk Categories

HR1 Household members of persons with tuberculosis or others at risk for close contact with the disease; recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific Islands); family members of migrant workers; residents of homeless shelters; or persons with certain underlying medical disorders.

HR2 Children with increased exposure to sunlight

HR3 Children living in areas with inadequate water fluoridation (less than 0.7 parts per million).

HR4 Children with chronic pulmonary or cardiovascular problems including asthma; or who required medical follow-up or hospitalization during the past year for chronic metabolic disease (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications)

HR5 Children aged two and over with chronic illnesses specifically associated with pneumococcal disease or its complications, anatomic or functional asplenia, sickle cell disease, nephrotic syndrome or chronic renal failure, cerebrospinal fluid leaks, or conditions associated with immunosuppression (including HIV).

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*This list of preventive services is not exhaustive. It reflects only those topics reviewed by the U.S. Preventive Services Task Force *and the AAFP Commission on Public Health and Scientific Affairs*. Clinicians may wish to add other preventive services on a routine basis, and after considering the patient's medical history and other individual circumstances. Examples of target conditions not specifically examined by the Task Force include:

Developmental disorders
Behavioral and learning disorders
Parent/family dysfunction

†Because of lack of data and differing patient risk profiles, the scheduling of visits and the frequency of the individual preventive services listed in this table are left to clinical discretion *(except as indicated in other footnotes)*. *Additional visits should occur as risk factors are determined. Achievement of developmental or social milestones, such as entry to junior high school, may also warrant a visit. Each visit by patients in this age group should be considered an opportunity to assess and address risks.*

American Academy of Family Physicians

Periodic Health Examination*

Ages: 13-18 Years

Schedule: *At least one visit for preventive services should occur[1]*
(See Preamble)

Screening

History	*Physical Examination*[2]	Laboratory/Diagnostic Procedures
Interval medical and family history[1] Dietary intake Physical activity Tobacco/alcohol/drug use Sexual practices	Height and weight Blood pressure *Tanner staging*[2] High Risk Groups Complete skin exam (HR1) Clinical testicular exam (HR2)	High-Risk Groups Rubella antibodies (HR3) VDRL/RPR (HR4) Chlamydial testing (HR5) Gonorrhea culture (HR6) Counseling and testing for HIV (HR7) Tuberculin skin test (PPD) (HR8) Hearing (HR9) Papanicolaou smear[3] (HR10) *Total cholesterol*[4,5] *Lipoprotein analysis*[6]
[1]*An updating of the previously obtained medical and family medical history is recommended by the subcommittee.*	[2]*A physical examination including Tanner stage is recommended at least once in this age group by the subcommittee.*	[3]*All women 18 years of age should have an annual Pap test and pelvic examination. All women between 13 and 18 who are or who have been sexually active, should also have an annual Pap test and pelvic examination. After a woman has had three or more consecutive satisfactory normal annual examinations, the Pap test may be performed at the discretion of the physician based on the assessment of patient risk but not less frequently than every three years.* [4]*Child of a parent with a blood cholesterol of 240mg/dL or higher.* [5]*Child of a parent or grandparent with a documented history of premature (age less than 55 years) cardiovascular disease.*

Ages: 13-18 Years

Counseling

Diet and Exercise	Substance Use	Sexual Practices
Fat (especially saturated fat), cholesterol, sodium, iron[7], calcium[8] *Nutritional assessment* Selection of exercise program	Tobacco: cessation/primary prevention Alcohol and other drugs: cessation/primary prevention Driving/other dangerous activities while under the influence Treatment for abuse High-Risk Groups Sharing/using unsterilized needles & syringes (HR11)	Sexual development and behavior[9] Sexually transmitted diseases: partner selection, condoms Unintended pregnancy and contraceptive options
[7]*For females.*		[9]*Often best performed early in adolescence and with the involvement of parents.*
Injury Prevention	**Dental Health**	**Other Primary Preventive Measures**
Safety belts Safety helmets Violent behavior[2] Firearms[10] Smoke detector *Noise induced hearing loss*[9]	Regular tooth brushing, flossing, dental visits	*Breast self-examination*[11] *Testicular self-examination*[12] High-Risk Groups Discussion of hemoglobin testing (HR12) Skin protection from ultraviolet light (HR13)
[9]*Especially for males.* [10]*Education regarding hearing loss from recreational and personal listening devices is recommended by the subcommittee.*		[11]*The teaching of self breast examination is recommended by the subcommittee at the time of initiation of pelvic examinations.* [12]*The teaching of self testicular examination is recommended by the subcommittee for male patients.*

Immunizations and Chemoprophylaxis

Tetanus-diphtheria (Td) booster[13]
High Risk Groups
Measles-mumps-rubella (MMR) vaccine[14]
Fluoride supplements (HR14)
Influenza vaccine (HR15)
Pneumococcal vaccine (HR16)
Hepatitis B vaccine (HR17)

[13]*Once between ages 14 and 16.*
[14]*A second measles immunization, preferably as MMR (Measles, Mumps, and Rubella Vaccine, Live), is recommended by the subcommittee for all patients unable to show proof of immunity who are entering post-secondary school education and for those becoming employed in medical occupations with direct patient care.*

Additional Notes

Leading Causes of Death:	Motor vehicle crashes Homicide Suicide Injuries (nonmotor vehicle) Heart disease	Remain Alert For:	Depressive symptoms Suicide risk factors (HR11) Abnormal bereavement Tooth decay, malalignment, gingivitis Signs of child abuse and neglect

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Ages: 13-18 Years

High-Risk Categories

HR1 Persons with increased recreational or occupational exposure to sunlight, a family or personal history of skin cancer, or clinical evidence of precursor lesions (e.g., dysplastic nevi, certain congenital nevi).

HR2 Males with a history of cryptorchidism, orchiopexy, or testicular atrophy.

HR3 Females of childbearing age lacking evidence of immunity.

HR4 Persons who engage in sex with multiple partners in areas in which syphilis is prevalent, prostitutes, or contacts of person with active syphilis.

HR5 Persons who attend clinics for sexually transmitted diseases; attend other high risk health care facilities (e.g., adolescent and family planning clinics); or have other risk factors for chlamydial infection (e.g., multiple sexual partners or a sexual partner with multiple sexual contacts).

HR6 Persons with multiple sexual partners or a sexual partner with multiple contacts, sexual contacts of persons with culture-proven gonorrhea or persons with a history of repeated episodes of gonorrhea.

HR7 Persons seeking treatment for sexually transmitted diseases; homosexual and bisexual men; past or present intravenous (IV) drug users; persons with a history of prostitution or multiple sexual partners; women whose past or present sexual partners were HIV infected, bisexual or IV drug users; persons with long term residence or birth in an area with high prevalence of HIV infection; or persons with a history of transfusion between 1978 and 1985.

HR8 Household members of persons with tuberculosis or others at risk for close contact with the disease; recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific Islands); migrant workers; residents of correctional institutions or homeless shelters; or persons with certain underlying medical disorders.

HR9 Persons exposed regularly to excessive noise in recreational or other settings.

HR10 Recent divorce, separation, unemployment, depression, alcohol or other drug abuse, serious medical illnesses, living alone, or recent bereavement.

HR11 Intravenous drug users.

HR12 Persons of Caribbean, Latin American, Asian, Mediterranean or African descent.

HR13 Persons with increased exposure to sunlight.

HR14 Persons living in areas with inadequate water fluoridation (less than 0.7 parts per million).

HR15 Children with chronic pulmonary or cardiovascular problems including asthma; or who required medical followup or hospitalization during the past year for chronic metabolic disease (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications).

HR16 Children aged two and over with chronic illnesses specifically associated with pneumococcal disease or its complications, anatomic or functional asplenia, sickle cell disease, nephrotic syndrome or chronic renal failure, cerebrospinal fluid leaks, or conditions associated with immunosuppression (including HIV).

HR17 Homosexually and bisexually active men, intravenous drug users, recipients of some blood products, persons in health related jobs with frequent exposure to blood or blood products, household and sexual contacts of HBV carriers, sexually active heterosexual persons with multiple sexual partners diagnosed as having recently acquired sexually transmitted disease, prostitutes, and persons who have a history of sexual activity with multiple partners in the previous six months.

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Developmental disorders
Behavioral and learning disorders
Parent/family dysfunction

†*Additional visits should occur as other risk factors are determined such as initiation of sexual activity, experimentation with alcohol or other drugs, or licensure for operating a motor vehicle. Achievement of developmental milestones such as entry to high school may also warrant a visit. Each visit by patients in this age group should be considered an opportunity to assess and address risks.*

American Academy of Family Physicians

Periodic Health Examination*

Ages: 19-39 Years

Schedule: Every 1-3 Years[1]

(See Preamble)

Screening

History	Physical Examination	Laboratory/Diagnostic Procedures
Interval medical and family history[1] Dietary intake Physical activity Tobacco/alcohol/drug use Sexual practices	Height and weight Blood pressure[2] *Pelvic examination (for women)* *Clinical breast exam (for women)*[3] *Clinical testicular exam (for men)* High-Risk Groups Complete oral cavity exam (HR1) Palpation for thyroid nodules (HR2) Complete skin exam (HR5)	Nonfasting *or fasting* total blood cholesterol[4] Papanicolaou smear[5] High-Risk Groups Fasting plasma glucose (HR6) Rubella antibodies (HR7) VDRL/RPR (HR8) Urinalysis for bacteriuria[6] (HR9) Chlamydial testing (HR10) Gonorrhea culture (HR11) Counseling and testing for HIV (HR12) Hearing (HR13) Tuberculin skin test (PPD) (HR14) Electrocardiogram (HR15) Mammogram (HR3) Colonoscopy (HR16)
[1]*An updating of the previously obtained medical and family medical history is recommended by the subcommittee.*	[2]*At every physician visit, with a minimum of every two years.* [3]*Every 1-3 years, starting at age 30 until age 40.*	[4]*At least every five years.* [5]*All women 18 years of age and over should have an annual Pap test and pelvic examination. After a woman has had three or more consecutive satisfactory normal annual examinations, the Pap test may be performed at the discretion of the physician based on the assessment of patient risk but not less frequently than every three years.* [6]*The optimal frequency for urine testing has not been determined. In general, dipsticks combining the leukocyte esterase and nitrite tests should be used to detect asymptomatic bacteriuria.*

Counseling

Diet and Exercise

Fat (especially saturated fat), cholesterol, complex carbohydrates, fiber, sodium, iron, calcium[1]
Nutritional assessment
Selection of exercise program

[1]For women

Substance Use

Tobacco: cessation/primary prevention
Alcohol and other drugs:
Limiting alcohol consumption
Driving/other dangerous activities while under the influence
Treatment for abuse

High Risk Groups

Shunning/using sterilized needles & syringes (HR18)

Sexual Practices

Sexually transmitted diseases: partner selection, condoms, anal intercourse
Unintended pregnancy and contraceptive options *for men and women*

Injury Prevention

Safety belts
Safety helmets
Violent behavior[2]
Firearms[2]
Smoke detector
Smoking near bedding or upholstery

High Risk Groups

Back conditioning exercises (HR19)
Prevention of childhood injuries (HR20)
Falls in the elderly (HR21)

[2]Especially for young males

Dental Health

Regular tooth brushing, flossing, dental visits

Other Primary Preventive Measures

Breast self examination[3]
Testicular self examination[3]

High Risk Groups

Discussion of hemoglobin testing (HR22)
Skin Protection from ultraviolet light (HR23)

[3]*The teaching of self breast examination is recommended by the subcommittee at the time of initiation of pelvic examinations.*
[3]*The teaching of self testicular examination is recommended by the subcommittee for male patients*

Immunizations and Chemoprophylaxis

Tetanus diphtheria (Td) booster[1]

High Risk Groups

Hepatitis B vaccine (HR24)
Pneumococcal vaccine (HR25)
Influenza vaccine[2] (HR26)
Measles-mumps-rubella vaccine (MMR) (HR27)

[1]Every 10 years
[2]Annually

Additional Notes

Leading Causes of Death:
- Motor vehicle crashes
- Homicide
- Suicide
- Injuries (nonmotor vehicle)
- Heart disease
- *HIV infection (males)*[1]

Remain Alert for:
- Depressive symptoms
- Suicide risk factors (HR17)
- Abnormal bereavement
- Malignant skin lesions
- Tooth decay, gingivitis
- Signs of physical abuse

[1]*HIV infection as leading cause of death among young adults in U.S. cities and states. JAMA 1993;269:2991-2994.*

Ages: 19-39 Years

High-Risk Categories

HR1 Persons with exposure to tobacco or excessive amounts of alcohol, or those with suspicious symptoms or lesions detected through self-examination

HR2 Persons with a history of upper body irradiation

HR3 Women aged 35 and older with a family history of premenopausally diagnosed breast cancer in a first degree relative.

HR4 Men with a history of cryptorchidism, orchiopexy, or testicular atrophy

HR5 Persons with a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions (e.g., dysplastic nevi, certain congenital nevi)

HR6 The markedly obese, persons with a family history of diabetes, or women with a history of gestational diabetes

HR7 Women lacking evidence of immunity

HR8 Prostitutes; persons who engage in sex with multiple partners in areas in which syphilis is prevalent, or contacts of persons with active syphilis.

HR9 Persons with diabetes

HR10 Persons who attend clinics for sexually transmitted diseases, attend other high risk health care facilities (e.g., adolescent and family planning clinics); or have other risk factors for chlamydial infection (e.g., multiple sexual partners or a sexual partner with multiple sexual contacts, age less than 20)

HR11 Prostitutes; persons with multiple sexual partners; or a sexual partner with multiple contacts, sexual contacts of persons with culture proven gonorrhea; or persons with a history of repeated episodes of gonorrhea

HR12 Persons seeking treatment for sexually transmitted diseases; homosexual and bisexual men; past or present intravenous (IV) drug users; persons with a history of prostitution or multiple sexual partners; women whose past or present sexual partners were HIV infected, bisexual, or IV drug users; persons living in long term residence or birth in an area with high prevalence of HIV infection; or persons with a history of transfusion between 1978 and 1985

HR13 Persons exposed regularly to excessive noise

HR14 Household members of persons with tuberculosis or others at risk for close contact with the disease (e.g., staff of tuberculosis clinics, shelters for the homeless, nursing homes, substance abuse treatment facilities, dialysis units, correctional institutions); recent immigrants or refugees from countries in which tuberculosis is common; migrant workers; residents of nursing homes, correctional institutions, or homeless shelters; or persons with certain underlying medical disorders (e.g., HIV infection)

HR15 Men who would endanger public safety were they to experience sudden cardiac events (e.g., commercial airline pilots).

HR16 Persons with a family history of familial polyposis coli or cancer family syndrome.

HR17 Recent divorce, separation, unemployment, depression, alcohol or other drug abuse, serious medical illnesses, living alone, or recent bereavement

HR18 Intravenous drug users

HR19 Persons at increased risk for low back injury because of past history, body configuration, or type of activities

HR20 Persons with children in the home or automobile

HR21 Persons with older adults in the home

HR22 Young adults of Caribbean, Latin American, Asian, Mediterranean, or African descent.

HR23 Persons with increased exposure to sunlight

HR24 Homosexually *and bisexually* active men, intravenous drug users, recipients of some blood products, persons in health related jobs with frequent exposure to blood or blood products, *household and sexual contacts of HBV carriers, sexually active heterosexual persons with multiple sexual partners diagnosed as having recently acquired sexually transmitted disease, prostitutes, and persons who have a history of sexual activity with multiple partners in the previous six months*

HR25 Persons with medical conditions that increase the risk of pneumococcal infection (e.g., chronic cardiac or pulmonary disease, sickle cell disease, nephrotic syndrome, Hodgkin's disease, asplenia, diabetes mellitus, alcoholism, cirrhosis, multiple myeloma, renal disease or conditions associated with immunosuppression)

HR26 Residents of chronic care facilities or persons suffering from chronic cardiopulmonary disorders, metabolic diseases (including diabetes mellitus), hemoglobinopathies, immunosuppression, or renal dysfunction

HR27 Persons born after 1956 who lack evidence of immunity to measles (receipt of live vaccine on or after first birthday, laboratory evidence of immunity, or a history of physician-diagnosed measles)

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*This list of preventive services is not exhaustive. It reflects only those topics reviewed by the U.S. Preventive Services Task Force *and the AMFP Committee on Public Health and Scientific Affairs*. Clinicians may wish to add other preventive services on a routine basis and after considering the patient's medical history and other individual circumstances. Examples of target conditions not specifically examined by the Task Force include:

Chronic obstructive pulmonary disease
Hepatobiliary disease
Bladder cancer
Endometrial disease
Travel related illness
Prescription drug abuse
Occupational illness and injuries

†The recommended schedule applies only to the periodic visit itself. The frequency of the individual preventive services listed in this table is left to clinical discretion, except as indicated in other footnotes

American Academy of Family Physicians

Periodic Health Examination*

Ages: 40-64 Years

Schedule: Every 1-3 Years[1]

(See Preamble)

Screening

History	Physical Examination	Laboratory/Diagnostic Procedures
Interval and family history[1]	Height and weight	Nonfasting *or fasting* total blood cholesterol[5]
Dietary intake	Blood pressure[1]	Papanicolaou smear[6]
Physical activity	Clinical breast exam[3]	Mammogram[7]
Tobacco/alcohol/drug use	*Pelvic exam*	High-Risk Groups
Sexual practices	*Digital rectal exam*[4]	Fasting plasma glucose (HR5)
	High-Risk Groups	VDRL/RPR (HR6)
	Complete skin exam (HR1)	Urinalysis for bacteriuria (HR7)
	Complete oral cavity exam (HR2)	Chlamydial testing (HR8)
	Palpation for thyroid nodules (HR3)	Gonorrhea culture (HR9)
	Auscultation for carotid bruits (HR4)	Counseling and testing for HIV (HR10)
		Tuberculin skin test (PPD) (HR11)
		Hearing (HR12)
		Electrocardiogram (HR13)
		Fecal occult blood/sigmoidoscopy (HR14)
		Fecal occult blood/colonoscopy (HR15)
		Bone mineral content (HR16)

[1] *An updating of the previously obtained medical and family medical history is recommended by the subcommittee.*

[3] *At every physician visit with a minimum of once every two years*

[4] Annually for women

[5] *The subcommittee recommends this procedure but recognizes that the scientific evidence may not be conclusive to support.*

[6] *At least every five years*

[7] *All women who are, or who have been sexually active should have an annual Pap test and pelvic examination. After a woman has had three or more consecutive satisfactory normal annual examinations, the Pap test may be performed at the discretion of the physician and the patient, but not less frequently than every three years.*

[8] *It is recommended that mammography be performed annually for all women beginning at age 50. It may be clinically prudent to perform mammography every one to two years in women between ages 40 and 49.*

Ages: 40-64 Years

Counseling

Diet and Exercise	Substance Use	Sexual Practices
Fat (especially saturated fat), cholesterol, complex carbohydrates, fiber, sodium, calcium[9] *Nutritional assessment* Selection of exercise program	Tobacco cessation Alcohol and other drugs: Limiting alcohol consumption Driving/other dangerous activities while under the influence Treatment for abuse High-Risk Groups Sharing/using unsterilized needles & syringes (HR19)	Sexually transmitted diseases: partner selection, condoms, anal intercourse Unintended pregnancy and contraceptive options
[9]For women		

Injury Prevention	Dental Health	Other Primary Preventive Measures
Safety belts Safety helmets Smoke detector Smoking near bedding or upholstery High-Risk Groups Back-conditioning exercises (HR20) Prevention of childhood injuries (HR21) Falls in the elderly (HR22)	Regular tooth brushing, flossing, and dental visits	Discussion of hormone replacement therapy in women High-Risk Groups Skin protection from ultraviolet light (HR23) Discussion of aspirin therapy (HR24) therapy (HR25)

Immunizations and Chemoprophylaxis

Tetanus-diphtheria (Td) booster[9]
High Risk Groups
Hepatitis B vaccine (HR25)
Pneumococcal vaccine (HR26)
Influenza vaccine (HR27)[10]

[9]Every 10 years
[10]Annually

Additional Notes

Leading Causes of Death:	Heart disease Lung cancer Cerebrovascular disease Breast cancer Colorectal cancer Obstructive lung disease *HIV infection (males)*[11]	Remain Alert For:	Depressive symptoms Suicide risk factors (HR17) Abnormal bereavement Signs of physical abuse or neglect Malignant skin lesions Peripheral arterial disease (HR18) Tooth decay, gingivitis, loose teeth

[11]*HIV infection as leading cause of death among young adults in U.S. cities and states. JAMA 1993;269:2991-2994.*

(High-Risk Categories listed on following page.)

*This list of preventive Services is not exhaustive. It reflects only those topics reviewed by the U.S. Preventive Services Task Force *and the AAFP Commission on Public Health and Scientific Affairs*. Clinicians may wish to add other preventive services on a routine basis and after considering the patient's medical history and other individual circumstances. Examples of target conditions not specifically examined by the Task Force include:

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Bladder cancer
Endometrial disease
Travel-related illness
Prescription drug abuse
Occupational illness and injuries

†The recommended schedule applies only to the periodic visit itself. The frequency of the individual preventive services listed in this table is left to clinical discretion, except as indicated in other footnotes.

The CHAIRMAN. Ms. Joyner, just to pick up briefly where Senator Pell left off in his questions, regarding osteoporosis, how can you encourage women to be more active in order to avoid or decrease the incidence of osteoporosis, or have some impact?

Ms. JOYNER. I believe education is one of the best ways. How do we educate women about osteoporosis and the benefits of exercising to prevent the onset of that disease? Through doctors. Doctors can provide them with information when they come for an examination. I think exercise should be the prescription for preventing that disease.

As for the women who do not go to the doctor, cannot afford health care to be able to visit doctors, we at the President's Council on Physical Fitness and Sports will have to go into those communities. We will ask for role models, parents, community organizations, to come in and help us so that we can go and deliver that message. So education is one of the best ways.

The CHAIRMAN. I suppose if you have school-based clinics as well, you will be able to get that important information out to young people at an early time in their lives.

Dr. Fleming, is the Cancer Society satisfied with the preventive package?

Dr. FLEMING. Yes, sir, except there is some disagreement in the area of mammography as far as screening versus diagnostic or preventive mammography. Our guidelines have been developed over a period of years, and the areas of controversy center around two issues. One, should women between the ages of 40 and 50 have any screening studies done with mammography, and second, should mammograms be done on a yearly basis as a screen, or every 2 years as a screen.

The CHAIRMAN. I think I heard the Secretary say they were going to increase the numbers for the higher-risk populations. Is that enough or not enough, or how shall we judge that?

Dr. FLEMING. I consider that a step in the right direction. I am not sure that is as far as we would like to see them go. What that does is it puts a burden on the physician to make a decision about risk. Now, there will be some easily identifiable risk factors, but you are still going to have the patient who is very concerned, may be a little difficult to examine, who wants a mammogram, and she will basically not be able to get it unless she pays for it herself.

The CHAIRMAN. Dr. Ludden, how does your HMO handle mammograms?

Dr. LUDDEN. We, as you can see from our report card, have an improving record that is in fact ahead of the Healthy People 2000 standards in terms of the number of our women over 50 that we are to get for mammography.

I think the important thing which is really a counterpoint to what was just said, or an additional point more than a counterpoint, is that we use a lot of systems to make sure that women get in for those exams; that is, the kind of computer-generated systems and so on. And while physicians are very important to make sure that screening and prevention occur, we found, for example, that in one of our centers, it was more important that the receptionist know that the woman was due for mammography than the physi-

cian, because the receptionist would make quite sure that the woman did not get out of their without an appointment for a test.

The CHAIRMAN. Continuing, Dr. Ludden, are you able to do this in a cost-efficient and effective way, and it has not increased your premiums significantly—or has it?

Dr. LUDDEN. Our premiums are close to and often at the bottom of the market in the Massachusetts area. We feel that we have been able to provide these kinds of screening services very cost-effectively. I would, I suppose, warn us all that some of the expenses come first, and the savings come later, and that is the nature of many of these kinds of prevention.

The CHAIRMAN. Dr. Francis, are you satisfied with the prevention package as you understand it, or do you have additional suggestions to make?

Dr. FRANCIS. I think by and large the Association is satisfied that most of our issues have been addressed. The need for comprehensive cardiovascular risk reduction and a widespread public education approach I think is really very important.

In getting to inner city communities, just referring to where I work, it has been very difficult to get the education message out and to get people to adhere. So I think there are going to be special efforts needed to reach inner city populations, and prevention is not a high priority when you are trying to deal with the major concerns of life.

That has been perhaps our most difficult sales job in trying to get our people in Harlem to even think about reducing cholesterol or stopping smoking.

The CHAIRMAN. It gets awfully hard if they are worrying about the next meal to start thinking about some of the things that we have been talking about here, or if they do not have a job.

Finally, Dr. Henley, is the methodology available for the kinds of evaluations that you think are so necessary in terms of the prevention package? I mean, have we moved along sufficiently as a society to be able to do more than sort of anecdotal information? Can you evaluate whether it is five visits or 11 visits for children? Can you really make a determination? Is there sufficient information out there so we can make that determination?

Dr. HENLEY. The methodology is there, Mr. Chairman. The current science produced by that methodology at times is lacking, but we feel that with appropriate efforts in research, many of those questions can be answered now, many of those questions can be answered in the near future. But it does come back to the issue of appropriate funding for that science to move forward, and we feel that the explicit-based methodology is the best approach to achieve that data. So that it takes into account the outcomes of the patient and the potential harms and benefits to the patient as we engage in these clinical preventive services.

The CHAIRMAN. Thank you. We will obviously be interested in all your views as soon as the fine print is out, but this has given us a lot of very good information on the preventive aspects of the administration's goals.

Senator Jeffords.

Senator JEFFORDS. Excellent testimony, and it is an area that I am very much interested in. You may have heard me this morning

ask the Secretary about nutrition and whether we should not try to ensure that our nutrition programs, especially for the economically disadvantaged, are adequate to provide good nutrition and would not be very helpful in the area of preventive medicine.

I wonder if I could get some reassurance on my thoughts there from anyone here.

Dr. HENLEY. With my work with the Academy, Senator, we have been involved in an effort called the nutrition screening initiative with the American Dietetic Association and the National Council on Aging. We have recently presented testimony to this Congress regarding the significant need, particularly in our elderly population, for appropriate emphasis on adequate nutrition and providing that nutrition.

We have identified clearly that it is really a simple matter in the primary care physician's office to identify patients at nutritional risk. It is easy to do that in our nursing homes and in our long-term care facilities.

The key, like in all preventive services, is to educate not only our patients, but our members of the Academy and all physicians, that these are services that we need to focus on; they can be accomplished, and if we emphasize the need to do so and perform that service, generally it can be done in a very organized fashion, at low cost, with minimal initial intervention.

Senator JEFFORDS. What about pregnant women and infants?

Dr. HENLEY. Well, nutrition clearly has no specific domain within an age group or agenda, and we certainly need to focus that in all of our health care avenues.

Senator JEFFORDS. Yes, Dr. Fleming?

Dr. FLEMING. Senator Jeffords, as far as nutrition and cancer is concerned, we have some clear clues about nutrition and breast cancer, nutrition and colon cancer, and you probably read this morning about nutrition and prostate cancer. There is a tremendous need for good research to come up with the reasons why these clues exist.

The problem with nutritional research programs is they are expensive and very long-term. What you do today affects you 20 years from now, and it makes it very difficult. But I think as we focus on preventive medicine, we should focus on preventive research.

Senator JEFFORDS. Yes, Dr. Francis?

Dr. FRANCIS. I think heart disease clearly has been a leader in identifying the relationship between diet and heart disease. I think the information with cancer suggests a long-term benefit, but with heart disease, we now have well-documented studies showing that low cholesterol diets actually cause regression of hardening of the arteries. I think this is an area that we are seeing now being implemented across the commercial, the FDA labelling rules and that kind of thing. I think that has really taken off from some of the earlier programs that the Heart Association was interested in advocating. So I think that for heart disease, diet and nutrition is probably a key factor; hypertension and low sodium; atherosclerosis and cholesterol; obesity, across the board with cardiovascular disease.

Senator JEFFORDS. The physician that I talked to suggested we ought to have some way to reward people who have good health habits, eating, drinking, whatever. I suggested this morning that it

might be a good idea, for instance, to give the plan or someone the opportunity to reduce the deductibles or reduce the copayments if you could get a stamp of approval from your physicians or whatever, to try to emphasize the importance of good health care, good nutrition and exercise.

Does that seem like something we ought to pursue or not?

Dr. LUDDEN. I would like to point out that in many ways, HMOs and managed care, with the prepaid nature of their insurance, get us down the road to being able to in fact reward a health plan, a group of providers, and allow us to turn that benefit around if we wish to other things, for encouraging exactly those things which are effective in prevention, that over time, we would see concrete results in terms of being able to do such things as smoking cessation or to take the cholesterol findings and integrate them into our nutrition support.

So on the whole, that matches the sort of thing that you are describing, without trying to get into the enormous problem of deciding exactly how you fiddle around with deductibles for individual people, which sometimes can create more hassle, and an atmosphere where what we are trying to do is break down the barriers that keep people from coming in and getting the care they need.

Senator JEFFORDS. What kind of reinforcement to reward people would you suggest, then?

Dr. LUDDEN. I am suggesting that the nature of a prepaid health organization is that the better you do—we do better and better at pap smear follow-up, or better and better at mammography screening, or better and better at smoking cessation, or better and better at cholesterol reduction—the benefits, even including the financial benefits, come back into the health plan and are returned to the membership of that health plan. That is the way the reward takes place.

The CHAIRMAN. You mean in additional kinds of services.

Dr. LUDDEN. Yes.

Dr. HENLEY. I would agree with Dr. Ludden. The reward for better health activity is in fact better health. That is the reward to the patient who responds positively to those types of programs.

As a practicing physician, it would be very difficult for me to track and identify patients that we may feel need to be penalized because of their bad health behavior. I sometimes know who they are and can identify them in the context perhaps of an office visit, but how do I continually identify whether they are smoking a year after I see them at "x" point in time, or whether they are continuing to abuse alcohol? Sometimes I can, sometimes I cannot.

The tracking of that—we create another whole bureaucracy that I think probably would cost more than providing the preventive services to begin with.

Senator JEFFORDS. Well, suppose you just rewarded those who could prove, and the burden was on them to prove that they are doing the good things; that does not create a bureaucracy, does it?

Dr. HENLEY. Proof is very difficult sometimes in these areas.

Senator JEFFORDS. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. We have a situation with cholesterol where Robert Kennedy's family all have a much higher cholesterol count than

my family does, for different reasons. I do not know how you would be able to quantify some of these issues, just individually.

The CHAIRMAN. We have had wonderful testimony from the Secretary and very, very powerful and compelling testimony from this group. We have a mother and a child who are here this morning, and I would ask the panel if they could remain for a few moments, because Ms. Sharon Moore and her son, DeMario Moore, have come to address the importance of preventive health, especially childhood immunizations.

DeMario is 5 years old—he has gotten off school today to come here—we will try to find him something to take back for "show and tell." We are delighted that you are here, and we want to welcome you both.

Ms. Moore, we very much appreciate your presence here. We know it is a difficult story, but it is a very powerful one, and we are very appreciative of the fact that you are willing to share it with us.

STATEMENT OF SHARON MOORE, MOTHER OF DeMARIO MOORE, ROCHESTER, NY

Ms. MOORE. Thank you, Senator Kennedy and other distinguished members of the committee on Labor and Human Resources, for the opportunity to tell you about my son, DeMario.

About 5 years ago, I was a single mother with two daughters, 11 and 2, and a 4-month-old son, DeMario. DeMario weighed 9 pounds when he was born and was in perfect health until he became ill with meningitis. Like all of my children, I took DeMario to the pediatrician at Anthony Jordan Community Health Center in Rochester, NY. Before he became ill, he had been to the clinic two or three times and had had the first set of shots. But our lives changed quickly when he came down with meningitis—something no child should ever have to go through today.

At first, DeMario was not acting very sick, but after a day or two, he would cry when I picked him up, even if I was trying to do something that would usually calm him down. I knew something was wrong, so I took him to the emergency room at Strong Hospital. That is when my nightmare began.

The doctors knew DeMario was very sick and immediately began to do blood tests and spinal taps. Since they did not know what he had for sure, they could not be very reassuring, and I just became more frightened and worried. When the results of the spinal came back, the doctors told me that DeMario had spinal meningitis. They said that he was very sick, and they were not sure whether he would live. They also warned me that if he did live, he may have some serious problems for the rest of his life. He could be deaf or blind or retarded.

I was alone, and I was hearing these things about my youngest baby. It hurts to remember.

The 11 days that DeMario spent in the hospital were a living hell. DeMario was in the intensive care unit and connected to all kinds of tubes, and I am sure suffering terribly with his illness. For the first day or two, the doctors were not sure whether he would live or die, and every time I heard or thought my baby might die, I thought I might die, too.

The doctors and nurses were wonderful, and DeMario did not die. He was still very sick, but when he left the intensive care unit, I knew he was going to live; I just did not know how many handicaps he would have to live with.

Before I left the hospital, I knew he could not hear. At first, there was some hope his hearing would return, but it has not, and it will not. We are lucky that he is not blind and generally enjoys good health, but DeMario's life has always included hearing aids, special tutors, and now special classes to help him grow up and do what other kids take for granted.

DeMario has learned sign language and tries to teach me and his sisters how to sign, so that we can communicate better. It has been hard to watch DeMario grow up deaf. He cannot play ball with other children, because if he does not see what is happening, he does not know what he is supposed to do.

At the same time, I am grateful that he is alive and otherwise normal. I am glad that his deafness was recognized early and that he has been getting help all of his life.

But all this is preventable now, and no other child should have to go through what DeMario has. That is the reason I agreed to come here today and speak to you. I do not think any child should have to suffer from a disease that can be prevented by vaccine. Every child in America should be able to get all the immunizations he needs, easily, as part of regular health. I am sure that thousands of kids could have been vaccinated for what it has already cost to treat DeMario for his illness and the deafness that has followed.

I am lucky that DeMario's younger sisters have gotten the vaccines to prevent meningitis. I know many other kids have not. I am grateful to President Clinton for making immunizations a top priority and including it as part of every child's health plan. I urge you to do all that you can as you change the health care system to make sure all children can get their immunizations easily. They deserve all the best chances for a healthy and happy life that we can give them.

Thank you again for the opportunity to speak. I am glad to answer any questions you may have.

The CHAIRMAN. Well done. Thank you.

As I understand it—and I will ask Dr. Van Dunn, who is a member of our staff, to correct me if I am wrong—but as I understand it, the immunization or vaccine which he could have taken was H-flu-meningitis; is that right?

Ms. MOORE. Yes.

The CHAIRMAN. And that was not available.

Ms. MOORE. No.

The CHAIRMAN. It has only become available in the last 2 years.

Ms. MOORE. Yes.

The CHAIRMAN. And I guess it is pretty certain that if it had been available and he had taken it, he would not have had this health problem. Is that your understanding as well.

Ms. MOORE. Yes.

The CHAIRMAN. And his sisters have had that shot?

Ms. MOORE. Yes, the 3-year-old and the 1-year-old.

The CHAIRMAN. So they both are covered. This really demonstrates so clearly what happens when we do not give attention to achieving the kinds of immunization programs that are included in this plan.

Well, I wish we knew sign. Senator Harkin does some sign because his brother is hearing-impaired, so if he were here, he would be able to talk to DeMario. But we are very, very grateful to you for being here today.

Ms. MOORE. Thank you.

The CHAIRMAN. Let me just ask you, Dr. Henley, in your community, what percent do you have totally immunized?

Dr. HENLEY. Of our 25,000 patients, Senator, I am happy to indicate that we are probably at about an 80 percent level. But that is unusual, and I understand that, and even though we have a fairly large portion of Medicaid patients, we have been able to work out arrangements with our local health department to allow for one-stop shopping, if you will, for immunizations, and that has made a big difference.

The CHAIRMAN. Terrific.

Dr. Ludden.

Dr. LUDDEN. Our childhood immunization statistics read in the 90 percent range.

The CHAIRMAN. OK. Dr. Fleming.

Dr. FLEMING. Mr. Chairman, if I may make just one other comment, in response to your question, I focused on the differences between the American Cancer Society and the proposed plan. The 2.5 million volunteers of the American Cancer Society strongly support the prevention and detection aspects of this plan. It is a major step forward as far as we are concerned in cancer control.

The CHAIRMAN. Good. That is terrific. And of course, eliminating the pre-existing condition—as the father of a son who lost his leg to cancer, as you well know, anyone who has those kinds of conditions as an individual finds it now virtually impossible to purchase any kind of coverage.

Let me ask you, Dr. Fleming, are you familiar with the center over in Grenoble that does a review worldwide in terms of preventive health care on cancer? They have studied different parts of the world, looking at eating habits and the incidence of cancer, such as the Japanese and stomach cancer, and Hawaii, where they have different kinds of cancer.

I had a briefing over there years ago, and I wondered whether you had any familiarity with that center?

Dr. FLEMING. No, sir, I am not familiar with that at all.

The CHAIRMAN. OK. Thank you all very much.

The committee stands in recess.

[Whereupon, at 1:45 p.m., the committee was adjourned.]

THE HEALTH SECURITY ACT OF 1993: AMERICAN BUSINESSES AND WORKERS RESPOND

FRIDAY, OCTOBER 15, 1993

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10:18 a.m., in room SD–430, Dirksen Senate Office Building, Senator Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Metzenbaum, Simon, Wellstone, Wofford, Kassebaum, Coats, and Gregg.

OPENING STATEMENT OF SENATOR METZENBAUM

Senator METZENBAUM [presiding.] Good morning. Senator Kennedy is at the White House, and Senator Metzenbaum tried to catch a few winks, since we got out of here at about one o'clock last night.

We are very happy to have all of you with us this morning. There is a concern on the part of the committee as to the reaction of the American business community, as well as the American labor community, as to the need for health care, its impact upon businesses at the present time, and how you look forward to its impact in the future.

It is particularly pleasing to me to have a witness from Ohio as the first witness. Ms. Diane Warren is the owner-operator of Katzinger's Delicatessen in Columbus, OH, and Eleanor Bonsaint is a child development journal editor at the Massachusetts Institute of Technology in Brookline, MA.

Senator Kassebaum intended to be with us this morning, but she has laryngitis, and a Senator that cannot speak just is not—so please proceed, and we are happy to welcome you.

Before we begin I have a statement from Senator Mikulski.

PREPARED STATEMENT OF SENATOR MIKULSKI

Good morning Mr. Chairman and distinguished witnesses. This is indeed an important hearing, as the response to the President's health care reform proposal from businesses and workers is critical to our deliberations.

This is more than a "how is it playing in Peoria" hearing. Doing right by our country in health care reform in large part means doing right by the businesses and workers who will bear the bulk of the price of this initiative. We need to listen carefully to what

these people have to say and take it to heart as we shape this legislation.

We should also never forget that American businesses and workers are also among the chief victims of the mess we are now in with health care in this country.

These are the companies who have to compete in a global marketplace carrying the burden of the world's most expensive health care system hidden in the cost of their products.

And these are the workers whose standard of living has declined in real terms for more than a decade partly because the exploding cost of health care has eaten away at their take home pay and kept employers from offering pay raises.

Lots of people are worried about the cost of this plan and you can count me among those worried about the effect on unemployment and small business in particular, but I'm even more worried about the cost of the status-quo.

As I've said before, its not just the health of our people at stake in this debate, its the health of our economy as well.

Let me just share a few facts from my own State of Maryland.

- In 1980 Maryland businesses spent $1.15 billion on health care for their employees. By 1992 that number was almost $4 billion—up over 250%!!!
- No wonder its tough to compete in the global marketplace.
- If things don't change the health care burden for Maryland companies will top $8 billion by the year 2000. And because many won't be able to afford that cost we will end up with more uninsured and underserved citizens.

And these rapidly increasing costs only tell part of the story, because the more we pay the less we get.

- Deductibles are up, copays are up, covered services are in decline, and employees have to pay an ever increasing share of the price of health insurance.

So the impact of these cost increases on workers is in many ways even worse than the impact on business.

- If health costs had not risen faster than the cost of living since 1980, the average Maryland worker would be taking home $1000 more in wages every year.
- In 1970, the people of Maryland spent just about the same amount on education as on health care. Today we spend twice as much on health care.

A major concern of everyone involved in this debate is how many jobs will be lost or created as a result of this initiative. I know I'd like to see reliable data on that question.

But another question which also should be answered is how many jobs we have already lost as a result of the uncontrolled cost explosion we have seen in the current health care system, and how many more jobs we would lose if we don't do something to fix it.

Mr. Chairman, I expect this hearing to shed important light on the cost of the reform the President has proposed, but we should always remember to measure that cost in the context of the hard realities of the alternative.

I look forward to the testimony to be provided today.

Thank you Mr. Chairman.

STATEMENTS OF DIANE WARREN, OWNER/OPERATOR, KATZINGER'S DELICATESSEN, COLUMBUS, OH; AND ELEANOR BONSAINT, CHILD DEVELOPMENT JOURNAL EDITOR, MASSACHUSETTS INSTITUTE OF TECHNOLOGY, BROOKLINE, MA

Ms. WARREN. Good morning. In October 1984, my husband Steve and I opened Katzinger's Delicatessen with 17 employees, a health insurance policy for our full-time management staff, and no money in the bank. We worked 7 days a week for a long time to grow this business. Today, we work 6 days a week, have around 35 employees and a great reputation, and a little bit of money in the bank.

Because we are a food service business, our staff is primarily young, part-time and healthy. And not incidentally, they are the backbone of our business.

Shopping for health insurance in 1984 was easy. Every few years, our rates would go up, a new company would come in with the lower quote, and we would switch carriers. We covered 100 percent of the premiums for our employees.

In 1989, the Central Ohio Restaurant Association endorsed a local insurance company and offered us group rates, rates far better than we were paying at the time. On June 1, we switched to this company.

In mid-June, during a routine pap smear, I was found to have cervical cancer. I had surgery in July and have remained cancer-free ever since.

However, at the end of 1989, the Restaurant Association withdrew its endorsement of this insurance company, recommending another company for its members. In my naivete, I called CORA, assuming that I was part of a large group and that, despite my cancer, I would still be able to get coverage for my employees with this new company. It was here that my education about health insurance began.

Of course, our entire group was refused health insurance because one member had a "pre-existing condition." But I was fortunate in that I had a choice—I could stay with our current carrier and thus stay insured, and although the rates were expensive, they were still manageable. Besides, I thought, in another year or two, if I stay healthy, someone will pick us up. After all, this is a cancer with a 95 to 99 percent cure rate.

I was wrong. No one would pick us up—not in 1990, 1991, or 1992. In the meantime, our rates were going up at about 40 percent a year, and we had to ask our employees to help by covering 20 percent of the costs.

In November 1992, we received the insurance company's proposed rates for 1993. To cover just my family—that is my husband, my child and myself—not including the rest of my group, the rate was $1,041 a month with a $2,000 deductible. There was obviously no end in sight as to how high these premiums could go, and this was the point where I panicked.

With the help of an independent insurance agent, I was able to find a company that would insure our group excluding "pre-existing conditions." The rates are fairly reasonable, but the deductible is

high, too high for most of my employees to handle, and the coverage is lacking. And of course, I have had to gamble on my cancer not returning.

Despite all this, it is clear to me that I am in a unique and ironically fortunate position. As the business owner, I could make the decisions about where the health care dollars are spent. I could pull money from the advertising budget, I could employ less people, I could not expand a certain area, or I could take a smaller salary to afford health insurance.

And from my vantage point, not having health insurance was not an option for me. I had had a serious illness. One day I was healthy, and the next day I was not. If it was me today, then tomorrow it could be my husband or my child. If we did not have health insurance, could we get proper medical care? I doubt it. If we had astronomical medical bills that we could not pay, would we lose our business, our home, and everything we had worked for? I think probably we would.

But Steve and I could make the financial decisions for Katzinger's based on our own self-interest; our business interest and our personal interest are the same. Assume for a moment, however, that it is not me, but one of my employees, who has a cancer diagnosis. It would take more wisdom than I possess to make the decision of whether to drop that person from our health insurance plan to keep our costs down and thus risk their personal health and financial security, or to bear the burden of astronomical costs and potentially risk the solvency of our business, the financial security of my family, and the jobs of 34 other employees.

Do my employees deserve the security of the availability of health insurance? Of course they do. It is good for them, and it is good for my business. I have both a moral and financial justification for wanting universal health care. I believe it is the right thing to do, and it is the smart thing to do. The bottom line is that healthy employees are more productive workers. And I am willing to take the responsibility for helping to provide insurance for them. But I need reasonable costs so I can stay in business or I will not be able to provide jobs, let alone health insurance. And I need the availability of health insurance regardless of our "pre-existing conditions" to do that as well.

I strongly support health care reform, but I recognize there are many small business people like myself who are opposed to health care reform. I can only say to them that they, too, are potentially one moment away from catastrophe. Any day, any one of you or a member of your family can be diagnosed with a serious illness. To you, it is a serious illness with all the personal upheaval that that implies. But to your insurance company, it is a "pre-existing condition" with all that implies. The bottom line here is that insurance companies do not want you if you are sick. And if you are a small businessperson, you have no leverage. There is potential disaster for all of us in the status quo.

Thank you.

Senator METZENBAUM. Thank you very much, Ms. Warren, for an excellent statement.

We will hear from Ms. Bonsaint first, and then we will have some questions.

Did I pronounce your name correctly?

Ms. BONSAINT. Well, in these wonderful United States, the French pronunciation, which is "Bonsaint," has been Anglicized, and it is now "Bonsaint."

First, I would like to express my most sincere appreciation for being invited here today and also to express my complete amazement that my letter, one of I am sure millions of other letters that have been mailed to the White House, actually got read. I consider that an astounding feat, and I have to say thank you to a very diligent staff for their extraordinary efforts. It simply means that all of the letters that are being written are being read.

Some of the concerns that I expressed in my letter to the First Lady and the President are what I would like to share with you today.

I would say that over the past 3 or 4 years, there has been such an outpouring of anxiety and fear and worry, for me and for many people, about how long is my health insurance coverage going to last; and for millions of others, such as in the case of my three sons, it is are they going to have health coverage at all.

Now, you may think this is a recent phenomenon, but it is not. In 1967, with four children under 6 years of age, I became ill and was hospitalized for 3 weeks. Shortly after returning home, my husband received a letter from his employer's health insurer, informing him that they would no longer provide health care coverage for our family. Now that I had a pre-existing condition, we could not avail ourselves of any other insurer, and if it were available, we absolutely could not afford the premiums for an individual policy. So for the next 5 years, we were without health insurance, with very, very young children.

These same four children today are adults themselves, and they have children. I would like to share with you their experiences with current health care coverage.

My married son Ronald works for a business that experiences seasonal layoffs. Because his employer cannot afford to pay his benefits while he is unemployed, he is without health care coverage. I assure you, with two children under 3 years of age, this is a serious problem for him and his wife.

My eldest son Michael works for a very small employer—they have three employees—and he has no health care coverage at all. His wages are rather small, and it really leaves him with no alternatives.

My daughter Marcell, who has worked for the same business for the last 8 years, has watched her employer shift from a fee-for-service policy to a PPO. This is a preferred provider organization that provides a list of doctors and health services for you, and you may choose from them when you need them. Initially, it looked very good, and after some time I asked my daughter how it was working out for her, and she said, "Mom, it is just useless. I do not now why I bother carrying it. Do you know what they tell me when I call some of these doctors on the list? They say they are sorry, but the doctor is not taking any new patients." So she is left with having to go outside her health care plan, at her own expense, whenever she needs health care.

My youngest son Jim just went through a period of unemployment and was recently hired by a well-established computer firm in Massachusetts. He has been hired as "temporary" worker. This allows the company to hire him without incurring the cost of benefits. So he, too, is without health care coverage.

Now, it may be helpful to the business to do this, but it does not help Jim at all. He also feels like no one really cares whether he has coverage.

As for myself, after working these past 22 years, I have joined a number of health care plans. Currently, I am with an HMO. You would think I would feel protected, but I do not. Last year, after a phone call to the American Cancer Society and the American Radiology Association, to find out if the mammography services offered through this health service met their accreditation standards, I found out they did not. In order to feel more secure about my mammography services, I go outside my health plan, at my own expense.

I must ask all of you here today this question: Why is it that in order to maintain or control costs, so many of us have no options at all to health care, which is the case with my three sons, and so many of us have extremely limited or marginal options, which is the case with my daughter and myself?

I wonder how long my children and my grandchildren and I have to continue to sit on this powder keg we call health care?

Thank you.

[The prepared statement of Ms. Bonsaint follows:]

PREPARED STATEMENT OF ELEANOR BONSAINT

I want to express my sincerest appreciation and gratitude for being invited here today, and I also want to express my profound amazement that my letter, one of a million letters that have poured into the White House over the past few months on health care reform, actually got read! It can only mean that all the letters that people have so carefully written on this topic are also being read.

Some of the health care concerns I wrote about to Hillary Rodham Clinton and the President last March, I want to share with you today.

Over the past three or four years, there has been an outpouring of anxiety, worry and fear from families and individuals who wonder how long will their health care coverage last; and for millions of others, will they ever have any coverage at all. One might think that this is a recent phenomenon, but it isn't.

In 1967, with four children under six years of age, I became ill and was hospitalized for three weeks. Shortly after my return home, my husband received a letter from his employer's health insurer informing him that they would no longer provide health care coverage for our family. Because I now had a pre-existing condition, we could not avail ourselves of another insurer, nor could we afford the costs of an individual policy. As a result, our family went another five years without health insurance.

These same four children are today adults with children of their own, and these are their experiences with health care coverage:

My son Ronald, who is employed, experiences seasonal layoffs. Because it is too costly for his employer to provide benefits during a layoff, he loses his health coverage. With a wife and two children under three years of age, this is a serious problem.

My oldest son, Michael, who works for a very small business with three employees, has no health care coverage at all. Further, his small wages make it impossible for him to find alternatives.

Over the past eight years my daughter, Marcelle, has worked for the same company. During this time, her employer, in order to reduce costs, has shifted from a fee-for-service health policy to a PPO. This is a preferred provider organization that offers a listing of doctors to choose from. Initially, she thought it looked good. Some time later, I asked how it was working out, and she said: "Mom, it's totally useless. I don't know why I bother to have it. Do you know what happens when I call one

of these doctors on the list? They tell me the doctor isn't taking any new patients! So, I wind up with no one I can see on this list, and end up paying for everything myself."

My youngest son, Jim, after experiencing a period of unemployment, was hired by a well-established computer firm in Massachusetts as a "temporary worker". This category allows a company to eliminate benefits from the cost of hiring. It may have benefitted the employer, but it left Jim without any health care coverage, and it also left him feeling as if no one cared if he didn't have it.

After working these past 22 years, in and out of health care plans each time I change jobs, I am now under an HMO. Do I feel protected? No. After a phone call to the American Cancer Society, I found out that the mammography services offered through this health service do not meet their accreditation standards. In order to feel more secure about mammography services, I go outside my health plan for care.

I must ask all of you here today why it is that so many have no options at all, which is the case with 3 of my children, and why so many have limited options, which is the case with my daughter and myself?

How long do my children, my grandchildren and I have to continue to sit on this powder keg called health care?

The CHAIRMAN. Thank you very much, first of all, to the witnesses. I apologize for being late. I think Senator Metzenbaum mentioned, I was called to a meeting at the White House on this very subject, and I am grateful to Senator Metzenbaum, who has been one of our strongest and most forceful advocates on health care reform, for moving ahead with the hearing. So I do apologize to our two witnesses for my tardiness.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. At the outset, I want to say that I know how difficult it is to talk about the health care challenges that face our families. I think for most of us, these involve very personal aspects of our lives, and it takes a good deal of coverage to be willing to share these experiences in public, so I am personally grateful to both of you for being willing to share your experiences with us and reviewing your own current situations.

We are going to hear a great deal about the costs of health care, but what we hear about so rarely are the costs in human terms, the anxiety that afflicts parents about their children not being covered. How can you put a dollar figure on the fact that they go home, and they see their children, and they think about their grandchildren, and they worry about their own coverage every day? Where does that come out in the total dollar amounts? We do not account for these costs very well. And certainly, that has been true in the whole health care debate.

As Senator Metzenbaum and I hear from people—and each of these stories is different—people will say, "Well, you can always find one person who has that problem," or "Here they go again. They searched all around to come up with those two people." But as Senator Metzenbaum and I know, you can find these stories in every single small community and large community, not only in my State and in Ohio, but across this Nation. I think that is sort of beginning to get through now to people; certainly, the President and Mrs. Clinton understand that very well. These problems are out there, and they are affecting people every single day.

And hopefully, as this debate has begun and as we attempt to deal with the issues, some of those who are expressing the greatest opposition to these efforts—and there are many out there, and by

and large, they are people who are doing very well under the current nonsystem—will come around.

One of the points, Ms. Bonsaint, that is often made, and I think you have made it very well today, is are we going to have choice. In the President's program, there will be, in terms of individual employees being able to choice various kinds of programs, and the doctors being able to move from one group to another. That is very unique. I have been in this debate for a long time, and they have made very strong efforts to try to provide some choice. But the point that I think many of us understand, and you pointed out so well, is that you have no choice today. We have 40 million Americans who have no health care, and probably another 50 million who, even under President Reagan, have completely inadequate health care, and those people have no choice of doctors. By and large, the employer is the one who is making the choice, not the employee.

We hear a lot about that, and I am just wondering if you want to make a comment about the issue of choice and what you understand to be the limitation of your opportunity to choose under the current system.

Ms. BONSAINT. I realize that it has only been in the last 2 or 3 years that this has really come to the forefront of our society, but I have been experiencing this for the last 25 years, personally experiencing the shortcomings in a health care system that is marvelous by any other standards in the world—but it is not available to anyone, and the means to correct it are not available, such as in my case, where I find the mammography services through my health care plan are not accredited. But I cannot change that. Can I change the health plan? No, because I do not have other choices.

It is frightening to watch my children in situations where they do not have health care coverage, but they all work. That is a real concern. It actually makes me very sad to think that we are all contributing members of society, and it feels so undeserving to be shortchanged, where I feel we are.

The CHAIRMAN. Again, these are hardworking people who are prepared to make some contribution to a good program that will try to provide that coverage. As you know, there are very strong provisions in the program in terms of preventive care, with mammography, pap smears and so on, that will meet the standards.

We have had continuing willingness to provide even greater coverage in terms of mammography, understanding the differences of age and situations of people, and we will be working on that. But that is obviously enormously interesting.

Ms. Warren, as a small businessperson, with high premiums and high deductibles and pre-existing condition, do you ever consider dropping your health insurance?

Ms. WARREN. As I said in my statement, Senator Kennedy, it is not an option for me because I have had a serious illness, and I know how financially devastating that would have been for us had we not had health insurance. So what my husband and I have done instead is cut in other areas—not grown our business to its potential in order to maintain health insurance for ourselves and our employees.

It is not an option for me because of my personal experience, and consequently, it is also not an option for my employees either. And with some of them, I have to say, "Look, you have got to do this." I have to do the "Mom" thing with them, because a lot of them are young, and they think they are going to live forever and never get sick. And I have so say, "No—you really should have health insurance. Trust me. You really need this." And some of them will buy into it, and some will not.

The point is that the potential for catastrophe is something that people do not recognize until they are faced with it. I have a close friend who had a breast cancer diagnosis in April; at the same time, her husband lost his job. They are in their early 50's. They have 12 months left on their COBRA plan, and then what are they going to do? She is going to be having chemo for a long time. What are they going to do? What are they going to do?

I need answers from people like you guys as to what can be done in situations like that, because I have searched everywhere I know how, and there are no answers. Carriers will not pick you up. The medical community will not provide insurance for you free. You are not poor enough to get Medicare. You are not old enough to get Medicaid. What do you do?

The CHAIRMAN. As I understand, you have been a small businessperson for 9 years; is that right?

Ms. WARREN. That is right.

The CHAIRMAN. How do you feel about a mandate? This is one of the "hot button" items that people focus on. I would be interested as to whether you think if everyone is covered, all businesses, large and small, it would help and assist the smaller businesses? That is something that would be included. What is your general feeling about that?

Ms. WARREN. My husband and I are entirely in favor of that. I think that health care is so basic to our society. When I started having all the problems in 1989 when I got sick, I remember going home and saying to my parents, "What is going on here? This is America. I do not understand why we cannot get health care. I do not understand it." I think I was so naive prior to that that I was really stunned.

I think it should be mandated. It is fine with me if it is an employer mandate. That is fine with me. I do not really care how we all get it. I just think that we all should get it. I think in the long run, in 20 years or in 30 years—and this is a process, not an event—I think in the long run, we are going to find that as a society, we are far better off because we had prenatal care, our kids were immunized, we made steps all along the way to stay healthy, physically and mentally, that in the end we are going to reap the rewards for that. My child will have a better society because of that, and her children will.

The CHAIRMAN. Very eloquent and compelling testimony.

Senator Kassebaum.

Senator KASSEBAUM. I am sorry, Mr. Chairman, but I have laryngitis, and I just came to listen.

The CHAIRMAN. This was true last Friday, too, Nancy. [Laughter.] Thank you for being here.

Senator METZENBAUM. I hope that Senator Kassebaum has adequate health care coverage. [Laughter.]

Ms. Warren, where is Katzinger's located?

Ms. WARREN. Third and Livingston, in German Village. I brought a menu if anybody wants to see it. [Laughter.]

Senator METZENBAUM. Very good.

Ms. WARREN. Some of your staff, I understand, have been there.

Senator METZENBAUM. I will have to visit.

Ms. WARREN. I certainly hope you will. We need all the business we can get so we can afford our health insurance. [Laughter.]

Senator METZENBAUM. I will indeed. As I sat here, I was thinking to myself, you are obviously an intelligent person; you and your husband have a small business and apparently have done reasonably well. And Ms. Bonsaint is, as I understand, a child development journal editor at MIT, also certainly an intelligent person and aware of what is available and what is not. And I say to myself, there is something I do not understand—and I know we will hear a witness later in the day, although I am not sure I am going to be able to stay for the witness because I have another commitment—but the National Federation of Independent Business, as I understand, is opposed to the program. And I am saying to myself, I was in small business—I was in larger business as well—but it seems to me that we are talking about an issue with respect to which the administration has come forward with an answer. A perfect answer—no. They are willing to accept changes and make improvements.

There is unbelievable dedication of a President and his First Lady to a program. Never before in my experience since I have been here—I have not been here as long as Ted, but I have been here pretty long—have I known of a President and his First Lady who knew the details of legislation being considered by the Congress. They oftentimes take a position, and they get a summary from some staffer. But this President and Hillary Clinton not only know it, but they have been involved in creating it.

I am just wondering how do you explain, or do you have any rational explanation, for the fact that a group such as the NFIB would be making this tremendous effort to oppose this legislation? How do you comprehend that?

Ms. WARREN. I certainly cannot answer as to how they think, but my opinion is that businesses are afraid of cost. Many small businesses do not provide any health insurance for their employees at all, so for them it is an added cost.

I think that if I were a business that was teetering on the edge of extinction, and this would potentially tip me over, maybe I would think twice about having a health insurance plan for my employees.

But the flip side is that we pay astronomically not just financially, not just in lost productivity, but in a psychological and spiritual way, by not having health insurance right now. As Senator Kennedy said, I do not know how you place a value on that; I do not know how you place a dollar value on those kinds of spiritual, psychological things. But they exist, and in my opinion, that cost is too high for us to bear; as a society, that cost is too high for us to bear.

It is worth it for me to pay those dollars out of my pocket to get health coverage—that is more valuable to me than to see people not have the security and have the fear of what is going to happen if they do not have health insurance, and they have a serious illness. Or, in the short run kinds of things, I have employees who come to work, and they are sick. They should be going to a doctor. I tell them, "You cannot come to work sick. This is food service, guys. You are going to make the customers sick. You cannot do this." But they say, "I cannot afford to go to the doctor." Even those with insurance cannot afford to go to the doctor because the deductibles are so high.

Now, there is a cost here that somehow business associations I think are not recognizing, that what we are paying now is a lot; it is not just what we pay out of our pockets. It is this other stuff that we pay, these other ways in which we pay as well.

That is the only way that I can respond. It comes down to finances, but finances is not just money. Costs are not just money.

Senator METZENBAUM. Ms. Bonsaint, I think we would be remiss if we did not ask you for your thoughts on this very subject of health care, not just from your family's personal challenge, but you are a child development journal editor at MIT. What are your thoughts in that capacity with respect to the challenge of child development problems?

Ms. BONSAINT. I would say, for instance, with my experience with my grandchildren, that to watch the psychological impact on their parents and their ability to tolerate the anxiety of wondering every day, "I hope she does not fall, I hope she does not trip and bang her head. Where would we go if something serious should happen?"—as Diane just mentioned, those costs, we do not see in the bottom line of a balance sheet. But in worker productivity, we know that that is where it is showing. And the anxiety is picked up by our children; it goes sort of unspoken. But you start to feel a real lack of confidence in the country, in our business community that we depend so much upon, and a profound and deep lack of trust in people we must turn to when we are sick, wondering whether they are really concerned about me, are they concerned about our families and our children, or are they trying to cut corners because a dollar seems to loom up in front of them much more readily.

Those are my concerns.

Senator METZENBAUM. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. I would just say we had a wonderful mother testify here who talked about how she had to tell her children they could not ride bicycles because of her fear that they would fall. Parents of a young boy who wanted to play sports in school had to say, "No, you cannot play football or other sports, because something might happen to you."

As you point out, Ms. Bonsaint, it is a fact that in companies all over the country, at 3:30 in the afternoon, productivity begins to go down significantly and measurably, as parents worry about their children getting out of school and whether they are getting home safely.

We do not do as well figuring out the cost of these factors in dollars and cents. For instance, children get better quicker by 40 to 50 percent if they have a parent with them. That saves money someplace, but we do not do quite as well as the opposition does in terms of framing the debate, but I think many of us understand exactly what you are talking about. It is a very real and powerful factor, and the country ought to hear a good deal more about it.

Senator Wofford.

OPENING STATEMENT OF SENATOR WOFFORD

Senator WOFFORD. I am sorry I was in another meeting on health care, which is my wont. I will read your statements with great care.

Certainly one of the things that I hope happens on day one of our legislation is that pre-existing conditions as an exclusion are out, out, and gone from day one.

I appreciate very much what you have put forth today in your personal stories.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very, very much. We appreciate your being with us. We are very grateful to you.

Our next panel includes distinguished witnesses who will provide commentary on the President's plan from the perspectives of workers at firms large and small, and from the perspective of large businesses.

John Sweeney is the chairman of the AFL-CIO Health Committee and president of the Service Employees International Union and has been one of the most important national leaders on the issue of health care for many years. We are very pleased that he is able to join us today.

Peter Pestillo is the executive vice president for corporate relations at the Ford Motor Company. He and his company have been grappling with these issues for many years, and he brings a wide knowledge of how this issue affects not only his business, but other business as well.

Michael Peel is the senior vice president for personnel and human resources at General Mills, a company that is engaged in innovative activities to control health care costs. And for the record, I know that General Mills owns and operates Gordon's Seafood in Gloucester, MA.

Mr. PEEL. Yes, we do, Senator.

The CHAIRMAN. Let us begin with Mr. Sweeney.

STATEMENTS OF JOHN J. SWEENEY, PRESIDENT, SERVICE EMPLOYEES INTERNATIONAL UNION AND CHAIRMAN, AFL-CIO HEALTH CARE COMMITTEE, WASHINGTON, DC; PETER J. PESTILLO, EXECUTIVE VICE PRESIDENT FOR CORPORATE RELATIONS, FORD MOTOR COMPANY, DETROIT, MI; AND MICHAEL A. PEEL, SENIOR VICE PRESIDENT FOR PERSONNEL AND HUMAN RESOURCES, GENERAL MILLS, INC., MINNEAPOLIS, MN

Mr. SWEENEY. Thank you, Senator.

Mr. Chairman, members of the committee, thank you for the opportunity to testify on one of the most critical issues facing our Nation today.

After almost a century of struggle, we are on the verge of bringing much-needed reform to our Nation's health care system. We applaud the President and the First Lady for their courageous initiatives in tackling this issue.

Let me also take this opportunity to applaud the chair of this committee for your outstanding leadership in this area over the years.

The AFL-CIO has long been on record in calling for Federal legislation to assure all Americans access to quality health care at an affordable price. To this end, a resolution endorsing the President's proposal and committing the Federation to a strong effort to secure comprehensive health care reform was unanimously adopted by the delegates to the AFL-CIO convention last week.

We support the President's plan because it meets all of the AFL-CIO principles for reforming the current system. The plan eliminates existing barriers to coverage and guarantees every American access to a comprehensive range of benefits. The plan also includes strong measures to control costs and improve quality. Finally, the financial burden of this plan is fair and spreads the costs broadly and equitably across the population.

As you and your colleagues are well aware, Mr. Chairman, rising health care costs are burdening workers and employers in all levels of Government. A 1992 study by my own union, the Service Employees International Union, found that if health care costs had only grown as fast as the economy as a whole between 1980 and 1992, average real wages would not have declined, employers would be paying one-third less for health insurance for their workers, and the Federal Government would have saved $79 billion alone in 1992.

Health care costs now consume 14 percent of gross domestic product and will consume 20 percent of GDP by the end of the decade if nothing is done. Without reform, this Nation will be unable to make the kind of investments in human and physical needed if the United States is to be economically competitive in the 21st century.

For these reasons, the AFL-CIO strongly supports President Clinton's cost control strategy, which uses a blend of regulation and market pressures to bring costs under control.

Opponents of the President's plan have argued that with a little tinkering here and there, market forces alone would be sufficient to bring costs under control. This flies in the face of our experience over the past decade with deregulation in the health care industry. Reagan era reliance on market forces brought us the highest rates of increase ever. It should be a source of shame to us that in the richest Nation on earth, there are 37 million Americans without any form of health insurance whatsoever and millions more underinsured.

There are some opponents of the President's plan who argue that the benefit package is too generous and that we must limit the range of benefits available. The AFL-CIO would strongly oppose any such move in this direction. While comprehensive, the adminis-

tration's proposed benefit package is not goldplated health care and represents the minimum that all Americans should be entitled to.

The AFL-CIO is also supportive of the ways in which the President and his task force resolve some of the issues related to the financing of the health care reform effort. We have supported progressive financing that distributes the costs of health care reform as broadly and as equitably as possible. The Clinton plan requires all employers to contribute at least 80 percent of the cost of the average premium in their region. But many employers, especially those who pay poverty-level wages and provide no health benefits, are resisting and want more of the burden shifted to workers and their families. This would be exactly the wrong direction for the Congress to move.

The President has wisely declined to make taxation of health benefits a major part of his proposal. Union members have suffered real wage losses in recent years as they have struggled to maintain their current level of health care benefits.

Some employer associations who have complained bitterly about the cost of the employer mandate have ignored the significant benefits that many businesses will receive as a result of the President's plan. Aside from cost control measures, which will benefit both employers and workers, the plan calls for a cap on employer premium contributions of 7.9 percent of payroll. Many small businesses will benefit from Federal subsidies and will pay less for coverage than they do not.

The special concerns of health care workers must be addressed as part of national reform. Any cost containment system must ensure fairness for health care workers and seek to minimize worker displacement. Funds should be provided to retain insurance and help workers to match skills to health care sectors that have expanded service needs.

The President's initiative and his political commitment to health care reform offers the best hope for achieving our long-sought goal of universal health coverage. We intend to defend the Clinton proposal against those who will advocate that we move more slowly, that we make incremental changes, or simply ensure our current situation.

We are committed to spearheading a coalition of consumers, seniors, businesses—large and small—community groups and progressive providers to fight against those special interest groups defending their financial stake in the status quo.

Once again, I want to thank you, Mr. Chairman and the members of the committee, for this opportunity to testify. We look forward to working together with you to achieve health care that is always there and that is a reality for America's working families.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Sweeney follows:]

PREPARED STATEMENT JOHN J. SWEENEY

Mr. Chairman, members of the committee, thank you for this opportunity to testify on one of the most critical issues facing our nation today. After almost a century of struggle, we are on the verge of bringing much needed reform to our nation's health care system. For the first time in the history of the health care reform movement, virtually all of the major health care stakeholders—consumers, providers, and

public and private purchasers—are united in their call for comprehensive reform. There is a consensus that our current system is broken and must be fixed. We applaud the President and Mrs. Clinton for their initiative in tackling this issue, and I am pleased to be invited to testify before this committee on our views on the President's national health care reform proposal. Let me also take this opportunity to applaud the chair of this committee for your outstanding leadership in this area over the years.

The AFL-CIO has long been on record in calling for federal legislation to assure all Americans access to quality health care at an affordable price. To this end, a resolution endorsing the President's proposal and committing the Federation to a strong effort to secure comprehensive health care reform was unanimously adopted by the delegates of our biennial convention last week.

We support the President's plan because it meets all of the AFL-CIO principles for reforming the current system. The plan calls for universal access to care for all Americans, regardless of health or employment status, real cost control, quality improvement, and fair and equitable financing.

Health care costs continue to eat up a growing share of corporate revenues, crippling the ability of U.S. businesses to compete in the global marketplace. A recent study by Employee Benefit Research Institute revealed that health care costs consume over 14 percent of payroll in the consumer products sector, over 11 percent in manufacturing and mining and construction, and over 10 percent in the transportation sector. These high costs are consuming resources that could otherwise be used to fund other critical national priorities. High costs are also exacerbating the potential competitive advantage that unscrupulous businesses can gain in the marketplace by not providing health care benefits to their employees.

President Clinton's reform proposal would dramatically improve the situation of workers, their families and the businesses for whom they work. It would also alleviate pressure on state and federal government budgets which are being severely strained by health care inflation rates often running at more than three times the Consumer Price Index.

A recent study by the Service Employees International Union (SEIU) and Lewin-ICF examined the effects of health care cost inflation since 1980 on workers, business, and government. The study compared their actual experience with what they would have experienced if health care inflation had grown only at the rate of overall growth in the economy (an average of 8.3 percent per year over 12 years). The study concluded that if health care inflation had been held to 8.3 percent per year:

- Real wages would not have declined.
- Employers would be paying an average of $1,015 less per employee per year for health insurance coverage—a savings of one third.
- The smallest businesses would be helped even more and would be paying $1,283 less per employee per year, on average.
- U.S. companies would be more competitive, with health care in the U.S. consuming roughly the same proportion of GNP as it does with our major trading partners (instead of 1.5 to two times as much).
- Our states would have had an extra $34.9 billion available in 1992.
- The federal government would have saved $79 billion in 1992 alone.

In addition to suffering cuts in real wages due to rampant health care inflation over the past 12 years, working families have been paying more out of pocket for health care as employers have tried to shift more of the burden of rising costs to their employees.

A 1991 study by Families USA found that the share of health insurance premiums paid by workers increased markedly between 1980 and 1991. In 1980, employees paid 18 percent of the cost of employer-sponsored health insurance. By 1991, that percentage had increased to 23 percent. If this trend continues, the average worker will be contributing 26 percent of the cost of their health insurance. It is important to bear in mind that this is an average, and that millions of workers will be paying much more.

These figures illustrate the profound need for health care reform, and what we stand to gain from it. Cost control is vital if we are going to reduce the economic burden that runaway health care costs place on the budgets of workers, businesses, and state and federal government. If present trends are not reversed, health care will consume one-fifth of our national income by the year 2000, diverting society's scarce resources from pressing investments and social needs.

For these reasons, the AFL-CIO strongly supports President Clinton's cost control strategy, which uses a blend of regulation and market pressures to bring costs under control. Opponents of the President's plan have argued that, with a little tinkering here and there, market forces alone would be sufficient to accomplish this

task. This flies in the face of our experience over the past decade with deregulation in the health care industry. Reagan-era reliance on market forces brought us the highest rates of health care cost increases ever. Furthermore, no other nation on the planet relies solely on the market to control health care costs. While the specific regulatory tools vary from country to country, all nations with national health care systems have imposed some kind of limit on the amount they spend on health care.

It should be a source of shame to us that in the richest nation on earth there are 37 million people without any form of health insurance whatsoever. As many as 50 million more are underinsured and often do not discover the crucial gaps in their health insurance until it is too late. In addition to the high cost of health insurance, many individuals and families are denied coverage because their employer does not provide health insurance coverage or because of pre-existing conditions that the insurance company refuses to cover.

Universal coverage is also an important element in cost containment. Uninsured persons still seek care, often through very costly and inefficient mechanisms. These costs are passed on by providers to their paying customers, the insured population. Under the President's plan, the financing burden of covering the uninsured will be distributed fairly and equitably.

The members of the AFL-CIO have long supported a universal right of access to health care. President Clinton has heard that call. The administration's plan would eliminate existing barriers to coverage and guarantee every America access to a comprehensive range of health care benefits. No one would be denied coverage because of their income, health or employment status.

There are some opponents of the President's plan who argue that the benefit package is too generous and that we must limit the range of benefits available. The AFL-CIO would strongly oppose any move in this direction. While comprehensive, the administration's proposed benefit package is not "gold plated" health care and represents the minimum that all Americans should be entitled to.

The AFL-CIO is also supportive of the way in which the President and his team of advisors resolved some of the issues related to the financing of the health care reform effort. For many years the Federation has argued that health care reform should be based on progressive financing that distributes the costs of health care reform as broadly and equitably as possible.

The Clinton plan requires all employers to contribute at left 80 percent of the cost of the average premium in their region. But many employers, especially those who pay poverty level wages and provide no health benefits, are resisting and want more of the burden shifted to workers and their families.

This would be exactly the wrong direction for Congress to move in. It would encourage employers to seek the "low wage path" to competitiveness. The Clinton plan, by requiring that all employers contribute, begins the process of taking benefits "out of competition" and denies unscrupulous employers the ability to gain a competitive advantage by denying needed benefits to their workers.

The AFL-CIO is also strongly opposed to "individual mandates," which would shift the responsibility for providing health coverage from employers to families. Many employers would end up dropping their health plans, forcing middle class workers to foot the bill.

The President has wisely declined to make taxation of health benefits a major part of his proposal. Union members have suffered real wage losses in recent years as they have struggled to maintain their current level of health care benefits. While union members will be asked to contribute through taxation of the kind of supplemental benefits found in the top tier of health benefit plans, the plan provides a ten year period during which wages tradedoff for health benefits in recent years can be built back.

Some employer associations have complained bitterly about the cost of an employer mandate and have ignored the significant benefits that many businesses will receive as a result of the President's plan. Aside from cost control measures which will benefit both employers and workers, the plan calls for a cap on employer premium contributions at 7.9 percent of payroll. The majority of businesses who now provide health insurance to their employees currently pay more, and therefore, stand to gain a windfall under the plan. The President's proposal also calls for a lifting of the heavy burden on businesses competing in the global marketplace by subsidizing the crippling costs of early retiree health care costs.

Some members of congress are suggesting that the Clinton plan is financing reform on the backs of small business. This is not the case. While small businesses which are not now providing benefits to their employees will clearly pay more under the President's proposal, many small businesses will pay less for better benefits under the plan. The special subsidies for small businesses will make the plan par-

ticularly attractive for small businesses who now offer health benefits to their employees.

The special concerns of health care workers must be addressed as part of national reform. Any cost containment system must ensure fairness for health care workers and seek to minimize worker displacement. Funds should be provided to retrain insurance and health workers to match skills to health care sectors that have expanded service needs, using appropriate providers, settings and delivery arrangements.

We continue to believe that nothing short of full scale restructuring will solve the current crisis of the health care system. The AFL-CIO will continue to oppose proposals for change that rely on uncontrolled market forces, incremental measures, or that focus on taxing the health care benefits that workers and their families have fought for over the years. Such measures will only serve to delay comprehensive reforms.

President Clinton's initiative, and his political commitment to health care reform, offer the best hope for achieving our long sought goal of universal health coverage. We intend to defend President Clinton's proposal against those who will advocate that we move more slowly, make incremental changes, or simply endure our current situation. We are committed to spearheading a coalition of consumers, senior citizens, businesses (large and small), community groups, and progressive providers to fight against those special interest groups defending their financial stake in the status quo.

Once again, I want to thank Senator Kennedy and the other members of the committee for this opportunity to testify. We look forward to working with you to make President Clinton's vision of "Health Care That's Always There" a reality for America's working families.

The CHAIRMAN. Mr. Pestillo.

Mr. PESTILLO. Thank you, Senator, and I thank you and your colleagues for having us here today.

Comprehensive health care reform probably is the most significant domestic issue facing our Nation today. The President and Mrs. Clinton really ought to be applauded for their courage in forcing the issue and taking a bold approach.

I can tell you that Ford employees view health care coverage as fundamental to their quality of life. But major and persistent increases in health care costs are making today's benefits more expensive than America can afford. For example, Ford health care costs have more than tripled since 1970, and now amount to more than $5,000 per employee and retiree.

It is not just the sheer dollars alone. These costs jeopardize our ability to compete globally because U.S. health care system and its costs are out of line with the rest of the world. In 1991, U.S. per capita health care costs were nearly double those of Germany and more than double those in Japan. That translates to about a $500 per car disadvantage for each car and truck we build.

Labor and management cannot fix this problem alone. Ford costs have continued to increase despite the close working relationship with the UAW, with insurance carriers and providers on numerous cost containment programs such as managed care, case management, and wellness programs. In 1992, these cost reduction efforts helped Ford save more than $200 million. But that was not enough. Even with that, for example, Ford's average annual health care cost increase of 8 percent over the last 5 years, although half that for industry at-large, was still double the rate of growth in the consumer price index.

We congratulate the administration for their leadership in developing a health care reform proposal that we really believe is a meaningful step in solving this serious national problem we have.

It addresses in a comprehensive way all the principles that we at Ford believe are key to successful reform—universal coverage, cost containment, quality assurance, equitable financing, and administrative simplicity.

There are several provisions included in the proposal that are essential if reform is to improve the competitiveness of U.S. business.

First, there must be limits on how much our Nation can spend on health care. Every business in America has to live within a budget that eliminates inefficiency and concentrates resources on the most productive output. It only makes sense that we do this for health care, as do the nations with whom we compete. A budget will force the elimination of unnecessary claim forms, excess hospital beds, unnecessary operations, and other areas of waste that are in our present system.

If we simply build efficiencies into the system that save even one percent of the U.S. GDP, we would save $60 billion. That money could be translated into improved international competitiveness and spent on such things as education, roads, and research and development, which would improve our standard of living.

Second, if we are going to have an employment-based health care system, we need all employers to contribute. Today, businesses providing health care coverage are subsidizing those who do not in the form of dependent care. There may need to be relief for some small businesses, but major exemptions will exacerbate this cost-shifting.

Third, we need to level the playing field by using broad-based financing mechanisms to fund health care for retirees, as other countries do. Ford is willing to bear our fair share of health care costs, but the U.S. cannot afford to give jobs away to foreign competition based solely on the way they pay for health care. In an employer-based system, all retirees must be treated the same. It would be severe discrimination to fund health care for those workers not covered by company programs at the expense of those who are.

If the plan that emerges from the Congress contains these elements, we believe the competitiveness of Ford and other American businesses will be helped over the long run. It should reduce the rate of growth in health care costs and eliminate the cost-shifting that has resulted in major companies paying 128 percent of the hospital costs their employees generate. The benefits will depend importantly on the financing and success in achieving the reduction in the rate of growth of health care costs.

On the other hand, piecemeal reform could achieve the opposite result. If universal coverage is provided with adequate cost controls, if cost-shifting from other companies and from Government to private industry is continued or increased, if there is discriminatory treatment for companies with older work forces located in urban areas, American competitiveness could be further disadvantaged if we do not address these issues.

In the end, we must step up to health care reform because we are the only industrialized Nation that does not provide universal coverage, and because health care costs are really out of control. Without prompt action, as Mr. Sweeney indicated, by the year 2000, with that much of our GDP committed, it will cost more than $14,000 per family for health care costs. Nobody will be able to afford coverage if we do not do something soon.

In summary, the health care system is broken and must be fixed at the national level. The solution must be comprehensive in nature—piecemeal reforms simply do not work. The President's plan should help make health care costs more affordable, provide universal coverage, and improve our competitiveness.

So we urge the Congress to move forward promptly on comprehensive health care reform. A successful solution will benefit all Americans and businesses large and small.

Thank you.

The CHAIRMAN. Thank you very much.

Mr. Peel.

Mr. PEEL. Thank you, Mr. Chairman and members of the committee.

I have a written statement that I would request be included in the record.

The CHAIRMAN. Yes; all the statements will be printed in their entirety in the record.

Mr. PEEL. Thank you very much.

Senator WELLSTONE. And a Minnesota hello to you, Mr. Peel.

Mr. PEEL. Thank you, Senator Wellstone.

I appreciate the opportunity to testify today. My testimony will really cover three subjects. The first is General Mills' company experience, operating in the current and rapidly changing health care environment. Second, I would like to cover our fundamental beliefs with respect to health care reform that come from this operating experience. And finally, I would like to comment on the administration's proposed health care plan in its current form.

With more than 126,000 employees, General Mills is one of the 25 largest employers in the United States. Unlike many major U.S. corporations, our employment is growing sharply as we added 19,000 jobs last year alone and more than 60,000 new jobs since 1988.

Approximately two-thirds of our sales is in the consumer foods business while the other one-third is in the sit-down restaurant business. Thus, we are both a major manufacturer as well as a significant participant in the rapidly growing U.S. service economy.

The businesses that General Mills compete in are intensively competitive, and we have long had a very strong financial incentive to control our health care costs. As a result of innovative and aggressive management of health care costs, our health care is currently costing 5.6 percent of payroll in our consumer foods business and 4.3 percent of payroll in our restaurant business. Our per capita health expense grew only 1.6 percent from 1991 to 1992 and actually fell from 1992 to 1993.

The strategies we have employed to contain our health care costs have emphasized heavy use of managed care networks and a strong emphasis on wellness and preventive care. In Minnesota where our consumer foods operations are headquartered, we helped found the Business Health Care Action Group, which is perhaps the most developed model of managed competition currently operating in the Nation.

In Florida, where our restaurant business is headquartered, we helped establish the Employers Purchasing Alliance, in which all employers, large and small, public and private, purchase health

care through the Alliance on the same terms. This Alliance has actually led to health care cost reductions for the entire Orlando community in each of the past 2 years.

General Mills employees also have a range of financial incentives to help control health plan expenses. The amount of money that employees contribute for their medical coverage is based upon their fitness and lifestyle as well as their actual year-to-year utilization of our medical programs.

Our hands-on health care reform experiences in Minnesota and Florida have led to rather strong opinions about what actually works and what will not.

These basic beliefs about health care are as follows. First, containing the rapidly escalating costs of health care must be reform's primary objective. Health care must be affordable for individuals, employers, and the Government, and must not undermine our global competitiveness.

Second, all Americans should have access to quality, affordable health care. And third, attempts to regulate people into behavior that does not make economic sense for them will ultimately fail. Economic incentives, not regulation, must reward consumers, providers, and payers for making appropriate choices about health care utilization, coverage, and cost and penalize those who do not.

We have reviewed carefully the Clinton administration proposal on health care reform. Certain aspects of the administration's program are right on target, particularly features such as universal access to affordable care, purchasing coops to enable individuals and small employers to purchase health care efficiently, portability of health insurance, and the elimination of rating discrimination based on pre-existing conditions.

However, there is much in the Clinton plan that we believe is seriously flawed and likely to harm most of the very Americans the plan seeks to aid. Despite claims to the contrary, the plan prescribes a Government-run, regulation-based system, instead of providing the right incentives to encourage marketplace competition on quality and on value. Fixing an employer's maximum health care cost exposure at 7.9 percent effectively rewards those companies that have been the least efficient providers of health care while removing any employer incentive to manage costs below the 7.9 percent level, as we and others have done. The lack of incentives for employers and individuals to contain costs is the most serious problem we see with the administration's plan.

The CHAIRMAN. Well, just on this point, though, they would be able to keep it. If you go below 7.9 percent, why wouldn't there be continuing incentives to go below it, because they could keep the savings?

Mr. PEEL. I do not think, Senator Kennedy, that most major companies would remain self-insured under the bill as proposed. I think most would opt for regional alliance coverage.

The CHAIRMAN. Well, just on the point—and I do not want to interrupt your flow—but you talked about disincentives to going below the 7.9 percent cap. In fact, they can go to where you are and still be able to retain those kinds of savings.

Mr. PEEL. But I think in the program as proposed, what would happen is that most major employers would opt out of their current plans and opt into the regional alliances with the caps as proposed.

In fact, I think the plan's provisions taken together make it unlikely that many large employers will set up corporate alliances. And without corporate alliances, there will be no competition, only huge Government-run regional alliances with no hope of controlling this major Government entitlement program.

The plan also mandates economic costs for employers of low wage or part-time workers that cannot rationally be covered by raising prices or reducing wages. This will hit the service sector of the economy hard, and that is the only sector of the economy reliably creating new jobs.

This burden placed on the service sector is compounded by the subsidies proposed for small businesses that are not available to large employers of low wage employees. Many small businesses are very profitable, while many larger employers operate on profit margins so thin they will not be able to absorb the significant cost increase.

I should also note that the 3.5 percent cap for small employers would take effect immediately, while the 7.9 percent cap for larger employers would not take effect for 8 years. The result could be as much as 20 times difference among competitors in health care costs in that time frame.

Finally, financing capped at 7.9 percent is unrealistically low, and the subsidies required to keep it at that level are likely to cost infinitely more than the current forecasts. We spoke about Germany, which has a reasonably efficient health care system consuming 8 percent of their GDP and financed by a 13 percent payroll tax. It defies logic to think that a system already consuming 14 percent of the GDP could be financed for so much less.

Most of the issues we see can be traced back to the plan's dependence on employer mandates for its financing, and as you will see in our written testimony, we favor a voluntary, incentive-based, managed care approach.

Mr. Chairman, I know my time is up, but I would be happy to try to cover these or other points in more detail during the question and answer period.

Thank you very much.

[The prepared statement of Mr. Peel follows:]

PREPARED STATEMENT OF MICHAEL A. PEEL

I appreciate the opportunity to testify today. My testimony will cover the two key issues in the health care debate: universal access and cost containment.

Our views on this subject are formed by our experience as a large and rapidly growing corporation headquartered in Minneapolis, which as you know, has long been a center of innovative approaches to health care.

Universal access

We believe that health care should be available to every American. Furthermore, no America should lose their coverage when they change or lose their jobs, divorce, or become sick. Pre-existing conditions should not prevent any American from getting health care coverage at the same cost as other Americans in their geographic area.

There are, obviously, a number of different ways that the objective of universal access to health care can be met. While legislation is needed to provide universal access to health care, common benefits, portability, ad assistance for low income

families, we must avoid mandates which will eliminate incentives for corporations and individuals to control health care costs.

The Administration has been most articulate on the problems of lack of health care access. All of these issues can be addressed with very straight-forward legislation. Universal access does not require a highly regulatory and mandate-oriented program.

Mandates destroy incentives

Unfortunately, the Administration's plan achieves universal access to health care via a mandated approach that sets health care costs at a flat percentage of payroll, thereby eliminating all incentives for corporations and individuals to reduce health care costs. Furthermore, the Administration's plan, with its state and federal regulators, global budgets, ad payroll taxes on employers will drive health care costs to unprecedented levels or result in rationed care. Mandates are the major problem with the Administration's plan.

Cost containment

By contrast, the current market-oriented approaches are beginning to result in substantial cost containment. For instance, CalPERS has told 18 managed care companies that it expects 5% roll-back in health care premiums next year.

At General Mills, we are having excellent cost experience in managing health care. We obviously have a major incentive to deal with this problem since success directly affects our productivity and competitiveness. Here is some background on the company and our approach to health care. With more than 126,000 employees, General Mills is one of the 25 largest employers in the United States. Unlike many major U.S. corporations, our employment is growing sharply as we added 19,000 new jobs in the past year alone ad more than 60,000 new jobs since 1988.

Approximately two-thirds of our sales are in the consumer foods business, while the other one-third is in the sit-down restaurant business. Thus, we are both a major manufacturer as well as a significant participant in the rapidly growing service economy.

As a result of innovative and aggressive management of health care costs, health care is currently costing 5.6% of payroll in our consumer foods business and 4.3% of payroll in our restaurant business. Our per capita health expense grew only 1.6% from 1991 to 1992 and actually fell from 1992 to 1993.

The strategies we have employed to contain our health care costs have emphasized heavy use of managed care networks and a strong emphasis on wellness and preventive care.

In Minnesota, where our consumer foods operations are headquartered, we helped found the Business Health Care Action Group which is perhaps the most-developed model of managed competition currently operating in the nation.

In Florida, where our restaurant business is headquartered, we helped establish the Employers Purchasing Alliance with other larger purchasers of care. This Alliance has actually led to health care cost reductions for the entire community in the Orlando area in each of the last two years.

General Mills employees also have a range of financial incentives to help control health plan expenses. The amount of money that employees contribute for their medical coverage is based upon their fitness and lifestyle, as well as their actual year-to-year utilization of the medical programs.

We believe that similar competitive pressures for productivity improvement will drive most American companies to do an increasingly better job of managing their health care costs.

Our "hands-on" health care reform experience in Minnesota ad Florida have led us to have fairly strong opinions about what actually works and what won't.

Regulation instead of competition

One of the major problems with the Administration proposal is that it has the potential to reduce competition among health care providers, not increase it. Each of the 50 states has the option of creating a single payer plan. This would result in no competition and either a dramatic escalation in cost or health care rationing.

Furthermore, we believe most corporations will not form corporate alliances.

Despite claims to the contrary, the plan prescribes a government-run, regulation-based system instead of relying on competition and market forces. Long-term, this plan would result in a single payer system in each state.

The plan relies on the existence of corporate alliances to provide competition for the regional health alliances, yet the plan's various provisions, taken together, make it unlikely that many large employers will set up corporate alliances. The potential costs ad restrictions the plan imposes for doing so make that a poor economic choice. Without corporate alliances, there is no competition—only large government-run re-

gional alliances with dubious prospects for hope of controlling the costs of a huge new government entitlement program.

Our current analysis is that we would not form a corporate alliance at General Mills. Many large companies, service ad industrial, are reaching similar conclusions as they absorb the full implications of the Administration's plan. Let me list the reasons why.

First, the Administration would impose a new tax, rumored to be at least 1% of payroll, on any corporate alliance. This tax would likely consume much of the "savings" a corporate alliance might generate. And, because the revenue is being counted on to fund the remaining portions of the Administration plan, there is a strong likelihood the "price of the privilege" will only increase over time.

Second, states are also granted unrestricted authority to tax corporate alliances further to pay for providing coverage. Since states are financially strapped, yet bear the responsibility under the plan for assuring universal coverage, it would be naive to think that corporate alliances would not be hit with additional state taxes for the privilege of remaining independent.

Third, the Administration plan would eliminate the ability of a employer to join with other employers to manage costs. The driving force behind the best efforts to reform our health care delivery system, initiatives like the Business Health Care Action Group in Minnesota and the Employers Purchasing Alliance in Florida, would be outlawed.

Fourth, because any individual employer would be small in comparison to the regional health alliance, costs could be "shifted" from the alliance to that employer, particularly when health alliance premiums are "capped."

Fifth, employers would be forced to deal with various rules and regulations in each state in which they operate. States could even compel employers to join mandatory single-payer systems. It will inevitably be easier and cheaper administratively to just send off a payroll-based premium to the health alliance.

Finally, employers opting for corporate alliances would forego the government guarantee of a fixed percentage of payroll for health care costs. Moreover, large employers with part-time workers, whom the plan requires to be covered by regional alliances, will forfeit the right to cap those premium expenses at 7.9% of payroll if they opt to cover their other workers in a corporate alliance. This means that for low-income employees, employers could easily pay 90% of wages in the case of a part- time worker receiving family coverage from a regional alliance.

Winners and losers

Fixing health care costs at a certain percentage of payroll for all employers would change the relative cost structures of every employer in the country. It would also create winners and losers within ad among industries.

Large manufacturers, rust-belt industries, companies with aging workforces, Fortune 500 companies offering very generous benefit plans—would likely benefit inordinately as the government assumes significant portions of their huge health care liabilities.

Many manufacturers, with older, skilled or unionized employees, pay 15% or more of payroll for health care benefits today. Under the Administration plan, that employer would see its costs reduced ad capped at 7.9% of payroll annually. Who would pay the difference between the current cost and the new maximum payroll percentage? Other companies who have done a good job of health care cost containment and taxpayers.

Other industries would lose. They include almost every low-wage sector of the economy, like domestic workers, child care providers and semi-skilled laborers. The entire service sector, the only part of the economy still reliably creating new jobs, could stall.

Industries in which low-wage, seasonal, or part-time jobs are common—agriculture, forestry, fisheries, food service, hospitality, amusement parks, construction, retail trade, business and personal services, have higher-than- average numbers of uninsured workers. They would be hit hard.

Those who should benefit from health care reform may pay the ultimate price for universal coverage—they could lose their job. While those who should benefit least—large manufacturers and employees with overly generous benefit plans—will receive sizable, guaranteed, government had-outs.

Part-time employees

Large employers of part-time workers are seriously disadvantaged by the Clinton Plan. Part-timers are 19% of the U.S. workforce—a significant segment. Most part-timers want part-time work. They are students, young parents, second earners or older workers who want or need flexible schedules.

Part-time jobs also offer opportunity and upward mobility. In the restaurant industry, 30% of restaurant management comes from the ranks of hourly employees, 70% of restaurant supervisors are women, and 20% are African American or Hispanic. One of General Mills' Vice Chairmen started as a hourly worker in one of our restaurants, as did the president of our Olive Garden chain, a $1 billion business.

A part-time job is the first exposure to the workplace for many Americans. Such positions offer entry-level employment and training to those whose education and skill levels do not qualify them for other work. The food service sector alone employs over 9 million people.

Service businesses employing part-time labor have low margins, and profits per employee are also low. The problem from a business perspective is weighing the economic value of a job to a enterprise versus the cost of providing that job. If the cost exceeds the value, the job is no longer sustainable.

Restaurant sales per full-time equivalent are only $47,300 per year, while manufacturing sales per full-time employee are $ 157,000 per year. Profits per service sector job are $500 versus $3500 in manufacturing.

Lowering direct wages to offset increased benefit costs in order to preserve the cost/value relationship is not an option with workers whose wages are already low. Price advances, which is the other option for covering increased costs, are difficult in today's economic climate and, under the Clinton Plan, virtually impossible because of the lower cost structure the plan gives smaller competitors.

Premium caps

We also have serious doubts that the premium caps—which, we might add, do not take full effect for 8 years and are not available to us if we maintain a corporate alliance—can remain at the level that has been proposed for very long and may even be breached immediately by the states. If Germans pay a 13% payroll tax to finance a health care system that consumes 8% of their GDP, it defies logic that premium caps at 3.5%-7.9% of wages can pay for a U.S. system that consumes 14% of GDP.

Our major recourse for dealing with the business economics that the plan dictates is to eliminate or consolidate jobs. Here's an example from a business perspective.

The proposed plan requires businesses to pay for part-time workers on a pro-rated basis. At ten hours per week, businesses would pay one-third of the 80% share. At 20 hours per week, businesses would pay two-thirds of the cost. At 30 hours or more per week, the employer would pay the full 80% share of premium costs.

An employer with two employees working 20 hours per week, would pay two-thirds of the 80% employer-mandate for each employee—or four-thirds. Common sense tells you that the employer will try to eliminate both part-time jobs ad create one 40 hour per week job and cut his health care costs by 25%.

Estimates of job loss in the service sector range from the high hundreds of thousands to 3.1 million. Studies are studies, and people will disagree about their conclusions, so I suggest you look at it this way: There are 375,000 eating and dining establishments in the U.S. and about another million retail establishments. If each one of them eliminated just one job, that would mean that 1.4 million jobs would be lost.

How to achieve full access and cost containment

Every American should have access to high-quality, affordable health care coverage. To achieve that goal, we favor careful reform of our health care system.

Universal access and cost containment do not require public price setting or excessive government intervention. With the right incentives to encourage competition on quality and value, the marketplace is much more likely than government budgets, caps or controls to deliver the highest quality health care at the lowest possible price.

Bureaucratic mechanisms that set prices and allocate resources are simply not effective in regulating dynamic markets. If they were, Medicare—already a price-controlled system—would have controlled health care costs in the Medicare system. It has not.

The formation of cooperative, actively-managed, member-controlled, non- government purchasing pools, or health alliances, should restore legitimate market forces in health care. These purchasing cooperatives should ensure open enrollment, measure quality, streamline administration and maintain consumer choice.

The purchasing cooperatives would negotiate with health plans to offer clear, understandable, competitive choices for consumers, who would retain the power to choose their own health plan.

The formerly uninsured and all government-subsidized purchasers should be required to join, with risk-adjustment mechanisms developed to balance any negative selection. Individual purchasers and most small groups would probably join immediately. They won't need to be coerced.

Each member of the HIPC would receive the same comprehensive benefit package, making it easier to compare price and value, with consumers, not employers, choosing annually among competing plans.

Employer contributions toward that premium would be tax-exempt to the employee, and tax-deductible for the employer, up to the level of the lowest-cost plan in the HIPC.

Premium payments should be 100% deductible for all individuals, including the self-employed, up to that same amount.

Health benefits or premium payments above that amount would be neither tax-exempt, nor tax-deductible.

Consumers who choose high-cost plans over cheaper ones should be willing to pay the difference with their own money—without tax subsidies. Eliminating the tax subsidy for overly generous health care benefits will help fund coverage for the uninsured, while creating cost-consciousness to hold down the cost of health care.

Statutes should outlaw pre-existing condition exclusions and other discriminatory rating practices. Portability and renewability should be guaranteed. Each of us is only a illness away from being sick instead of well. Health alliances should be community-rated, with some variations for age and utilization.

Subsidies should be directed to individuals, based on income, not to employers based on size or wage-rates, with full subsidies for those below 100% of federal poverty guidelines and sliding scale subsidies for those below 200%.

If additional subsidies are necessary on grounds of equity, access and social responsibility, tax revenues—not mandated employer frnancing—should be raised to fund them.

Managed competition would restore a functioning health care marketplace, weed out low-value health care spending, restore responsibility, and establish competition based on the cost and value of care consumed.

Conclusion

A regulatory, government-dominated approach is neither the best nor the only approach. Managed competition, in our opinion, would effectively restore the market forces necessary to control health care costs—and should form the basis for an emerging, workable, bipartisan approach to health care reform.

The CHAIRMAN. Thank you. Of course, in theirs, the Germans cover long-term comprehensive care. They even include spas. It is a somewhat different kind of comparison, I think.

Mr. Peel, your company currently provides fairly comprehensive insurance for your employees. Even for part-time workers—you cover up to 17 hours a week; is that right?

Mr. PEEL. Our part-time eligibility, Senator Kennedy, is 6 months of service and 25 hours per week.

The CHAIRMAN. And you pay a proportion of the premium?

Mr. PEEL. We make the coverage available, and the employee participates with the premiums, yes.

The CHAIRMAN. Good. That is a lot better than most companies.

We will have 5-minute rounds for questioning, and I will ask staff to keep track of the time

Do your competitors in the restaurant business provide comparable coverage?

Mr. PEEL. Most do not. The restaurant industry is a minimum wage industry where in many cases, particularly smaller restaurant operators do not.

The CHAIRMAN. And how does that affect your competitiveness? Do you think that that is fair?

Mr. PEEL. Well, we tend to provide better coverage than a lot of the smaller players, and that puts us at a bit of a competitive disadvantage, no question. But with the subsidies proposed, it would

reverse that relationship, where small restaurant operators would have their exposure on health care capped at 3.5 percent, while ours would be virtually uncapped until the 7.9 percent cap took effect late in this decade.

The CHAIRMAN. You are at 4.3 percent now.

Mr. PEEL. Yes.

The CHAIRMAN. And the 3.5 percent is, of course, for the lowest-paid employees.

I just want to come back to the other question. You provide coverage, and I think it is certainly a commendable decision, because you do not have to provide it, and you are in competition with people who do not provide it, yet you do. So I think that that is a commendable decision. But do you think that it is fair for others not to provide it? Does that bother you either as a competitor or as a human being? How do you react to that? [Laughter.] Those terms are synonymous in some sense.

Mr. PEEL. Well, many small restaurant operators are break-even businesses, and to the extent they had to provide medical care, many of them would cease to exist. So I think there is a number of restaurant operators who would like to provide coverage, but do not have the profit margins for employees to do that.

The CHAIRMAN. Of course, they were one of the top two in terms of employment growth over the last 6 months, so someone is doing okay in the restaurant business, because part-time restaurant workers is where that 1.2 million job growth has been over that period of time.

Mr. PEEL. But a change in health care might change that job growth.

The CHAIRMAN. That is what has always been said. We heard that with regard to minimum wage, and we have heard that with regard to a lot of other things. And the increase in the minimum wage, for example, the last time, all the studies showed it did not impact jobs, quite frankly, and we saved the Federal Government a good deal of taxpayers' money because these people were no longer eligible for the safety net programs. So that is something that ought to be looked at and examined, and we certainly will do that.

Mr. Sweeney, you represent workers in all the sectors of the American economy. Your own union represents the service employees. I want to bring your attention to the issues of cost and cost-shifting and retiree health costs. Is this an issue only for large, mature industrial companies, or is it widespread throughout the economy?

Mr. SWEENEY. It is really widespread throughout the economy, and we have heard many of the examples related to basic industries, but it is the same or similar experiences in the building and construction trades as well as retail and service trades. They are all sharing similar experiences in terms of costs being shifted and in terms of the experiences with retirees' health care costs.

The CHAIRMAN. Mr. Sweeney and Mr. Pestillo, Mr. Peel suggested that these problems can be effectively addressed without a mandate for the employers to contribute to the cost of coverage and without a budget to backstop the competitive forces. I want to give

each of you a chance to respond, and then I will ask Mr. Peel to respond.

Mr. PESTILLO. It is two issues, Senator. I think the budget is critical, so that we can have some targets at which to shoot and against which to measure ourselves. The budgetary process is common to any business or Government, and whether violated or not, at least it is a standard. So I think budgets are critical. At least it will tell us where we are vis-a-vis competition among the other nations of the world.

With respect to mandates, to the extent to which you continue to free people either to elect or not elect coverage, you will have probably even more hodge-podge of a system. That is, there will be ineffective alliances as well as independence, and I do not think you can achieve the kind of oversight or control of the problem that will let us begin to reduce the costs of health care.

Mr. SWEENEY. I do not think there is a business in the country that operates without a budget, and the only way we are going to control costs is with budget caps. Every other Nation's experience has been in that direction.

There is no way that we can accomplish universal access with any kind of voluntary programs. There have to be mandates if we are sincere about providing health care to every American.

The CHAIRMAN. We will give you the last word, Mr. Peel.

Mr. PEEL. There is no question that the health care system in the United States needs major reform. We believe strongly that that reform can be accomplished without mandates; that if health care is available and affordable that many employers would love to cover their people with health care, and that with reform, there will be a lot of people brought into the health care system, and we will move very far along the curve toward universal access, which is an important social goal.

The CHAIRMAN. Thank you.

Senator Coats.

Senator COATS. Thank you, Mr. Chairman.

Mr. Pestillo, I wonder if I could ask you some questions so that I can understand the basis for Ford's decision to support the administration's plan.

I appreciate your competitiveness problem with foreign competitors and the cost per employee. It has been well written and documented that automobile companies, under their union contracts, basically offer some of the best and most comprehensive health insurance coverage of any business, and I know that that is expensive.

Do you have the percent of payroll that Ford currently pays for health insurance coverage?

Mr. PESTILLO. Senator, yes, but the more compelling numbers are really in the aggregate because the active versus retiree—we have almost as many retirees as active, so the average hourly person carries about a $10,000 a year obligation for covering retirees, dependents, and the like.

Senator COATS. What is that percent of payroll?

Mr. PESTILLO. It is almost 20 percent.

Senator COATS. Twenty percent?

Mr. PESTILLO. Yes. We pay more for health care than we do for steel. And the total cost with the FASB effect is nearly $2 billion a year.

Senator COATS. So that going down to 7.9 percent is pretty attractive. [Laughter.]

Mr. PESTILLO. Senator, no, as a practical matter, it is not a free ride down, because with the proposed new taxes as well as the additional programs we do not provide, such as child wellness and office visits, those costs more than offset the costs of removing our early retirees.

Senator COATS. OK. What is the savings from going from 20 percent to 7.9 percent?

Mr. PESTILLO. The principal savings associated with what we will do, given those offsets, will be in the broader oversight that is cost control, in that shifting of the 28 percent which we do, and other efficiencies there. But we will indeed incur costs on the way down.

Senator COATS. So what is the aggregate number? What is the net savings.

Mr. PESTILLO. Hopefully, when we get down there, it will be toward $1 billion, but it will be a long time coming and——

Senator COATS. Toward $1 billion?

Mr. PESTILLO. Yes. I doubt if we would ever reach that—if indeed we will get to half of what we are now.

Senator COATS. Are you including the savings from the early retirement pickup on the part of the Government?

Mr. PESTILLO. Yes, which again are offset by the new coverage and the tax. That is a wash, effectively.

Senator COATS. But you are looking at a potential saving of $1 billion?

Mr. PESTILLO. Hopefully.

Senator COATS. That is a great incentive to endorse the plan. I mean, I do not blame you. If I were a businessman, I would endorse that plan, too, if I could save $1 billion.

Mr. PESTILLO. But it is not a gift $1 billion, Senator. It is the rough equivalent of what our competitors are doing today.

Senator COATS. Your foreign competitors.

Mr. PESTILLO. Right. And it is not merely the Japanese in Japan. The Japanese in the U.S. have an even greater advantage vis-a-vis the American companies because they do not have retirees. They have a younger work force, and they operate more nearly in rural areas; where most of our plants are located in large urban centers, where we have the burden of the uncovered people getting their health care as needed in the emergency rooms.

Senator COATS. It is still a great incentive.

Mr. PESTILLO. Absolutely.

Senator COATS. When you made your decision to go ahead and endorse the proposal, I am sure it was based on the fact that there was some certainty that with the plan that was proposed, you could count on the savings.

I have this very nice brochure here that is put out by the Department of Commerce that describes the administration's health security plan, and then it has a question and answer section in the back. The question is: Can you, the businessman, be confident that

the plan has been analyzed rigorously and that the financing is reliable? There have been a lot of press reports and so forth that the administration absolutely believes it is reliable, although that has really come under question in the last several weeks.

But quoting the answer to that, according to the administration, is: Yes. The President has brought together the best minds in the country to design this. The numbers and analyses that underline the President's proposed health plan represent months of vigorous work, etc, etc. These cost and savings projections are solid, credible, and conservative.

Yet I read in the Wall Street Journal this morning that, "The Clinton administration has decided to take back half of the early financial gains realized by companies that take advantage of a Clinton proposal in which the Government would pay most of the medical costs for early retirees."

They are now saying that half of the "windfall" gained by companies from the Government picking up 80 percent of the cost of early retirees' health care is going to have to be paid back. Because their cost estimates were not solid, credible, and conservative, they are having all kinds of problems with those cost estimates.

It says also, "Most notably, the administration is sticking by earlier estimates for Medicare and Medicaid savings." I think any of those of us either involved in the system or who understand the system really put a question mark on whether or not, politically, we are going to achieve Medicare and Medicaid savings to the extent the administration has suggested.

Then it says, "Officials also said that they have decided that large corporations will have to pay an annual surcharge of one percent of payroll."

Now, I guess my question is are you aware of this shifting plan relative to costs, and are the people at Ford starting to say, "Wait a minute. We based that endorsement on supposedly solid, conservative estimates, and now the plan has not even been introduced yet, and they are assessing us surcharges, taking back half of our 'windfall.'"

Are you sure you want to be as definitive as you are at this particular point?

The CHAIRMAN. Before you answer that, of course——

Senator COATS. Mr. Chairman, I would like the witness to respond.

The CHAIRMAN. Yes, but I would like the question to be accurate, factually. The administration has denied the Wall Street Journal article, and I think our witnesses are entitled to the facts on that.

Senator COATS. OK. Well, I said that this was from the Wall Street Journal.

The CHAIRMAN. And the administration has disputed that. I do not know if the witness has had the opportunity to see the administration's response to that story since he has been in this hearing room all morning; he ought to know about it.

Senator COATS. Let me rephrase the question, then.

Does it give you any pause?

Mr. PESTILLO. Senator, without accepting the term "windfall," by the way, I have been around long enough to say two things about my savings. Indeed, they are prospective, as I indicated; it will not

be all that money all at once. And second, they are indeed speculate as well. We are at risk on the costing, which in all good faith the administration has indeed formulated. They are affirming them. They are not rearranging them, I think. It is an issue.

And second, the last bill I remember coming through the administration unamended was the Highway Beautification Act. So there are a lot of issues that play before we get to enactment, and I am mindful that many things could change.

If, for example, as I have indicated, we deal dramatically differently with the early retiree issues, if we fail to have a broad mandate—there are potentials here that this could indeed cost the Ford Motor Company money. I think we feel it our obligation to step up on what we consider a broad national issue and take a position. But this is not a blank check either for the Senate or for the administration to say we will take whatever you come up with.

The proposal as we have seen it——

Senator COATS. Saves you $1 billion.

Mr. PESTILLO. Off in the distant future, Senator, off in the distant future; not tomorrow.

Senator COATS. Well, it is still $1 billion; $1 billion is $1 billion.

The CHAIRMAN. Senator Wellstone.

Senator COATS. I do not blame you.

Mr. PESTILLO. Not until you have it, Senator.

Senator COATS. But you know, somebody has got to pay for that $1 billion, and I guess that is what we are looking at, and we cannot seem to get an answer as to who is going to pay for it.

Mr. PESTILLO. Right, but we argue that the savings that are associated——

Senator COATS. It sounds like General Mills is going to pay part of it by moving their payroll tax from 4-something to 7.9 percent. So it is a nice cost shift for you, but I do not know what good it does for General Mills.

The CHAIRMAN. The Senator's time expired about 2 minutes ago. [Laughter.]

Senator COATS. Mr. Chairman, if I could just do a housekeeping matter.

The CHAIRMAN. You bet.

Senator COATS. Senator Durenberger regrets that, due to a death in the family, he is in Minnesota for a funeral. He particularly wanted me to extend his apologize to Mike Peel from General Mills. And I have a statement here that he would like put in the record, and he asks that his full statement be put in the record.

The CHAIRMAN. It will be included.

[The prepared statement of Senator Durenberger follows:]

PREPARED STATEMENT OF SENATOR DURENBERGER

Mr. Chairman, I am sorry that I am unable to attend today's hearing on "The Health Security Act: American Businesses and Workers Respond." Unfortunately, due to a death in my family, I have to be in Minnesota today to attend a funeral.

I particularly want to extend my apologies to Michael Peel, Senior Vice President of Personnel for General Mills in Minneapolis, MN. General Mills has been one of the national leaders in holding down health care costs and making quality health care available to

its employees. General Mills has a lot to add to the debate over how we reform our nation's health care system, and I know that Mr. Peel's testimony will be particularly illuminating to my colleagues.

Mr. Chairman, I want to commend you on the tremendous leadership you've shown on health care, and for focusing on the issues that will be addressed at today's hearing.

One of the important things I've witnessed, from my perspective on both the Senate Finance and Labor Committees, is the absolutely critical role that both employers and employees play in the current health care system, and the critical role they must play as we struggle to reform the system to deliver higher quality health care at lower costs.

I applaud President Clinton for preserving an employer-based system in his proposal for reform.

Many employers have been a creative force in containing health care costs. Under the current system, employers voluntarily contribute about $180 billion each year toward their employees' health care.

We should point out that the vast majority of Americans are satisfied with their current health care coverage primarily because employers have done a good and responsible job of making health care available. A recent survey by the Employee Benefit Research Institute found that over three-fourths (77 percent) of Americans rated the quality of their health care as either excellent or good, and only four percent said the quality of their care was poor.

General Mills has an excellent track record of holding down costs while making health coverage available to all of its 126,000 plus employees—both full and part-time. As a result of innovative and aggressive management of health care costs, General Mills is currently spending only 5.6 percent of payroll in the consumer foods business and 4.3 percent of payroll in the restaurant business on health coverage. The company's per capita health expense grew only 1.6% from 1991 to 1992, and actually fell from 1992 to 1993.

General Mills has been successful in containing health care costs largely through its heavy use of managed care networks and a strong emphasis on wellness and preventive care. One of the major reasons for General Mills' success in Minnesota, is its leadership in establishing the Business Health Care Action Group—perhaps the most developed model of managed competition in the country.

The success of General Mills and other companies doesn't mean that the current system is free from problems. It isn't.

The system needs to be reformed so that health care is available to all Americans.

There should be no bar to insurance based on pre-existing conditions, and no one should have to face the fear that they will lose their health insurance when they lose their job, change jobs, divorce, or become sick.

We also need to do more to bring down the cost of health care in order to ease the burden on both employers and employees, and help speed the availability of universal coverage.

As we begin to address the current shortcomings in our nation's health care system, both businesses and workers bring to the debate a great deal of hope—and a great deal of apprehension. Both

have much to gain from health care reform. But both also could stand to lose. As we work to reform health care, it is our duty to make sure that the benefits and the burdens of the system are distributed fairly.

No single employer views health care reform—or President Clinton's reform proposal—in exactly the same way. Each company's views are shaped to a significant degree by the size of their firm, the nature of their business, their location, the composition of their workforce, and the financial health of their company.

Similarly, employees bring differing perspectives and opinions based on how much they make, where they are employed, and by whom.

As we shall see more clearly from today's testimony, where one stands depends largely on where one sits.

As we work to reform the nation's health care system around our current employer-based model, we should keep in mind the following points:

- Employers should not be forced to give up control over health benefits, without gaining control over costs.
- Companies and corporate alliances that are already aggressively containing costs should be rewarded for the headway they have made already in saving money and developing cost-effective delivery systems.
- Arbitrary employer mandates only serve to reshuffle costs without delivering true reform because they don't take into account the economic diversity among small and large employers.
- Workers should have the flexibility to choose doctors and change jobs without losing their health coverage.
- We can't look solely to business for higher "contributions" to finance health reform. We need health care, but we need jobs too. We should never accept a "reform" that sacrifices jobs for health insurance.
- We can't force employers or employees to buy high cost plans. Before we address the coverage problem, we must address the cost problem.
- We can't have 50 different state health plans if we are going to have true national reform. At the same time, government in Washington doesn't have all the answers. We should be striving to set up national rules, that allow local markets to work. Markets are wiser than government.
- Universal access does not require a highly regulatory, mandate-oriented program. We must avoid mandates that eliminate incentives for companies and individuals to control health care costs.
- We should strive to build a partnership between business and government, not an adversarial relationship. Instead of mandating and controlling the health care market, government should ensure that the market operates efficiently to deliver value to all consumers.

The CHAIRMAN. Also, just in point of fact, it does not raise it, because it does not require them to go up to 7.9 percent. If they can get the savings, they can keep the savings. It would be useful to understand what the administration's bill is really all about when we are characterizing it.

Senator COATS. It sure would.

Mr. PESTILLO. Senator, could I answer that last point, if I may—rather than be seen as attempting to shift my costs to General Mills—our attention is to achieve the savings through a better distribution system. With 70 percent of our hospital beds utilized, we have got overcapacity that can be better controlled with, we think, a broader national plan.

And second, I think the way in which we deal with the 37 million currently uncovered, and better distribute the costs of caring for them, which we now share, is a better way to go about achieving the savings.

The CHAIRMAN. Senator Wellstone.

Senator WELLSTONE. Thank you, Mr. Chairman. These are interesting questions.

Let me just comment on what we have been talking about. I think Senator Coats' questions are interesting and important. This whole question of great incentive—I mean, part of what is going on in the country today is that in addition to some of the people in the past who have called for universal health care coverage, you have a business community along with many caregivers who are saying, "We really have to see the reform."

I think the twin evils, Mr. Chairman, are the skyrocketing costs and the plummeting security. So I do not know exactly what the Senator from Indiana means by "great incentive," but I say this as a strong single-payer advocate—and that is not for today—but as to what the President has proposed, I think it is a great incentive, and that is all in the positive, that there are people in the business community who see that we have to do something about these skyrocketing costs. And to the extent that this benefits the business community, and you can invest back into your company and back into what you produce in the automobile industry, and that creates more jobs, we are going to be much better off.

So I frankly do not have any problem with this working out well for important parts of the business community because I think it works out well for all of us. I just want to make that crystal clear, that this is not a problem, to talk about the great incentive. This is a plus. I would be more worried if you were talking about some sort of disincentive.

I want to ask a couple of questions. First, Mr. Peel, with the concept of companies self-insuring and the managed care plans, there is the issue, I think, of the relationship between an alliance or alliances that are set up at the State level to the networks that are going to be competing against one another, including if you are a company of 5,000 or over, nationally, you could self-insure.

My question is in terms of focusing on the market, do you see any need for some sort of public accountability with the self-insured plans? I will be specific. One of the things that people worry about is what do you do if a company that is self-insured, trying to keep costs down, should not want to hire a woman because her child is a diabetic, or somebody is laid off work because of a health care condition?

The one thing we are trying to get rid of is this experience rating. I am not talking specifically about your fine business, but is there a way that we can get a handle on this, as you see it?

Mr. PEEL. I think, Senator Wellstone, it is going to be academic under the Clinton plan as proposed because I do not think large employers will self-insure. The one to 2 percent surcharge, the fact that States have unlimited taxation on self-insured plans, and the fact that you forfeit that 7.9 percent cap if you remain self-insured, I think the economics work against self-insurance.

So I think as a practical matter, what will happen with companies like ourselves, who have been able to effect economies in the system by grouping with other employers, which is prohibited by the Clinton plan, as a practical matter, you will opt for the public system and cap your costs at 7.9 percent rather than experience the cost-shifting that will occur when you are a relatively small component in the broader system.

Senator WELLSTONE. Two minutes remaining? Did you take just 5 minutes, Senator Coats?

Senator COATS. Exactly. [Laughter.]

Senator WELLSTONE. You know, the chairman of this committee is always biased toward the Republicans. I have noticed that. [Laughter.]

Senator COATS. We have noticed that over the years. [Laughter.]

The CHAIRMAN. Now your time is up. How do you like that? [Laughter.] The Senator may continue.

Senator WELLSTONE. In the remaining 3 minutes that I have, let me ask you what your position is on the question of the universal coverage. Do you see that as being kind of a priority goal both in terms of making sure that people indeed are covered and also from the point of view of an argument, which I forget who made, that if you do not have that, you have the cost-shifting anyway? I mean, do you think that within these alliances, within what happens in the State, within what is set at the Federal level, that that should be a priority goal now?

Mr. PEEL. We believe strongly that universal access is a critical component. What we are really concerned with is how do you fund it; I mean, what is the most——

Senator WELLSTONE. OK. That is what I want to get to, is the funding part.

And then the second part, for all of you, on the package of benefits, the argument that is being made over and over again—and I feel like there is almost consensus on this, too—is that to the extent that you have a comprehensive package of benefits, heavily tilted toward primary care, toward preventive health care, toward delivering health care out in the community, actually toward health as opposed to health care—most people really do not want health care; they do not want to have to go to the doctor or to the hospital, but they want good health—it makes sense both from the point of view of humane, dignified care and cost-effectiveness.

Do you all see it as a priority to have as comprehensive a package of benefits as possible, tilted in this direction, or not? If each of you could answer that, and then I have concluded with my time.

Mr. SWEENEY. As I said in my testimony, I think that the core benefit package that the administration has been proposing is a good basic level of benefits. Knowing where I am coming from, any expansion of that benefit package, we would encourage, but I think

the basic level of benefits that the administration has proposed is excellent.

Mr. PESTILLO. Two parts, Senator. We clearly favor wellness program. I think over time they do save money. We employ them, and they are not shown as part of our health care costs. We do them routinely.

And with respect to the comprehensiveness of the package, I think you do have to have a comprehensive package. We might dispute a provision or two within it, but we accept the concept.

Senator WELLSTONE. Mr. Peel.

Mr. PEEL. We believe the plan, as we understand it, is a generous plan. And again the question becomes what are the costs over the longer term, and how do you fund them.

Senator WELLSTONE. If I do not get a chance to ask you today, because I may have to excuse myself, I would like to talk to you about what you would see as the alternative way. If we agree on those goals, and that is the commitment, and people are serious about it—and I know all of you are in good faith—then I would be interested in what you would see as the alternative way of financing it once we say it is what we really need to do as a Nation.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Senator Gregg.

Senator GREGG. Thank you, Mr. Chairman.

I would like to try to return to some of these numbers, Mr. Pestillo, so that I understand what the income shift here is.

How much does the early retiree package cost Ford Motor Company for people between the ages of 55 and 65? How much do you pay in health care benefits for that group?

Mr. PESTILLO. We do not currently disaggregate the data. I will provide the number for you, but I will have to gather it.

Senator GREGG. So what you have is a gross number of $2 billion that represents 20 percent of your payroll.

Mr. PESTILLO. Right.

Senator GREGG. And you would go down to 7.9 percent, which is in the $1.2 billion range.

Mr. PESTILLO. Well, Senator, let me pause on that because I might have misled you as to my savings. At 7.9 percent there is that dramatic saving, but we will not get down that far. We would anticipate, for example, paying the retirees 20 percent and the employees 20 percent. I do not expect our costs will ever get as low as 7.9 percent. The 7.9 percent does not embrace paying additional sums to the employees.

So that is why I said to the Senator our savings will not be that great, and they will indeed be prospective.

Senator GREGG. But they will be approximately $1 billion, prospectively.

Mr. PESTILLO. No. That is at 7.9 percent, Senator.

Senator GREGG. At 7.9 percent, it would be $1.2 billion.

Mr. PESTILLO. Actual, I think they will probably not be $500 million. I thought the Senator's question was what would it be at 7.9 percent.

Senator GREGG. Well, at 7.9 percent, it would be $1.2 billion. Well, it is going to be significant. If it is $500 million, $500 million

is real money, too. And I guess my question is where does that money come from. You are saying it is going to come from efficiencies in the program, and yet isn't this really an income transfer?

Any company that has 50 or more people and is not unionized and is between 50 and 500 employees and does not have an insurance package which costs it 7.9 percent of payroll is going to have to pick up insurance through the mandated premium, and that money, or tax—it is a payroll tax; it should be called a payroll tax and is a payroll tax—that money is going to go to Ford, will give you $500 million. I mean, that is the way it works under this system.

Mr. PESTILLO. Well, the issue is to what extent am I obliged to deal with the 37 million uncovered or those with less than what we will call comprehensive coverage, and the extent to which I deal with my early retirees. To me, those are broader social concerns than a mere windfall to the Ford Motor Company.

If I have 125,000 employees, and if we are to put them out in society without the coverage they currently have—something I am unwilling to do—we redistribute the costs that way. I shift my costs that way, and that is something I do not find attractive for us as a people.

Senator GREGG. Yes, I can understand that, but I guess what I cannot understand is that a mere windfall to Ford Motor Company is nothing something that I think the average person who has a small machine tool company, or maybe a restaurant with more than 50 employees, or maybe a couple gas stations, or runs an oil delivery business—a mere windfall of $500 million to Ford Motor Company so that those small, job-creating entities in this society can transfer their profitability, to the extent they have it, to Ford is not something that I think really excites a lot of small business America. I guess my question to you is if we are talking fairness and equity and social policy, which you seem to be identifying with, is this appropriate social policy?

Mr. PESTILLO. Most of the industrialized countries have broader and more comprehensive health care than we. I guess if that is social policy, then, yes, I would indeed support that.

Senator GREGG. Well, I think that in getting to social policy, you have to get to equity in treating small business people who are, it appears, going to get hit with a bill and the windfall falling on the larger corporations in this country.

I would ask Mr. Peel——

Mr. SWEENEY. Could I just respond, Mr. Chairman, to Senator Gregg, if I may?

The CHAIRMAN. Yes.

Mr. SWEENEY. This is not just a "small business versus big business" argument. There are many large corporations, real big business, that do not provide any health care whatsoever. Beverly Nursing Homes, with close to 100,000 employees across this country; Manpower Temp, one of the largest employers in the country—no health care.

Senator GREGG. Well, that is certainly part of the issue, and I do not think anybody is arguing the need to have broader health care availability and access. But the point that I am making, and

I think the point that Senator Coats is making, is that there is an income transfer occurring to accomplish this which is unfair on its face when you take companies that have 50 to 500 employees who are not unionized, and you stick them with a bill, the majority of which bill is going to land as a windfall to unionized companies that are big and can probably take care of themselves. If you are a small company, I think you find that a little tough to take in the craw. I mean, you are probably willing to pay something, and you are probably willing to deal with your insurance issues, but you are not willing to see an income transfer, which is what is happening under this proposal. And that is what happens under the mandated premium or the payroll tax approach to financing this, and that is the argument we have, that the payroll tax approach to financing this is the wrong way to finance it. We do not have an argument with what you have raised, Mr. Sweeney, which is access. That is a legitimate issue.

I guess my time is up. I did have a question for Mr. Peel, but I will get it on the next round.

The CHAIRMAN. Please go ahead.

Senator GREGG. Thank you, Mr. chairman.

Mr. Peel, how would you presume to address this issue if you had your druthers, since you do not seem to identify with some of the core problems in the Clinton plan?

Mr. PEEL. I think there are certain aspects of the system that are working, particularly the incentive that employers currently have and that employees currently have to contain costs. I think any solution should not destroy those incentives.

I believe strongly that regional purchasing cooperatives and the elimination of discrimination based on pre-existing conditions, and things that need to be done to shape the system in a way that everyone has access to affordable health care are imperative.

But I think in the same way that we have been able to group with other employers and effect not only economies for ourselves, but the broader community, that over-regulating the system would be a huge error.

Senator GREGG. Do you believe in community rating?

Mr. PEEL. I do not believe in community rating. I think that any solution will probably be such that employers, large and small, and individuals will be able to get affordable health care, and community rating often militates against that possibility.

Senator GREGG. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Just very briefly, because we need to move on to the next panel, Mr. Pestillo, the way I look at it, you are being asked to do your fair share, and that may be troublesome to other people, but you are doing more than your fair share today. You are covering hundreds of thousands of workers because you are paying more out of Ford, and the workers are paying more in the form of lost wages or other kinds of benefits, because others are not paying their fair share. I mean, that is what is happening today, and all I understand in this is that you are doing your fair share. It might bother some that others who have not done their fair share are now being asked to do it. That is evidently bothering some people, but to me it seems like an issue of simple equity.

Let me ask you, Mr. Peel, they have done a remarkable job of retaining costs at General Mills. What has been the record in the last several years? Has it been equal to what you have outlined here today—say for the last 5 years, how much have the premiums gone up in your company?

Mr. PEEL. As I testified, in the last 2 years, it has been relatively flat, with a 1.8 percent increase in 1991-1992 and an actual decrease in 1992-1993. Before that, it was accelerating at a much higher rate, and through the managed care networks we have joined and through, frankly, the wellness and preventive care work we have done over the past 20 years, it is starting to come down very sharply. We are encouraged by what we see with coalitions of employers particularly, bargaining for the best quality and best value health care.

The CHAIRMAN. I am trying to get some understanding as to what it was going up previously and what it has gone up in the last couple years. In the last 5 years, what has been the increase in your premium, generally?

Mr. PEEL. Five years ago, it was going up in double digits, and it has progressively come down over that 5-year time frame.

The CHAIRMAN. Good.

Senator Coats.

Senator COATS. Just a comment, Mr. Chairman, and then a couple brief questions.

Relative to the fair share question, that implies that General Mills, which pays—did you say 4.7 percent of payroll——

Mr. PEEL. A little over 5 percent in consumer foods, and 4.6 in restaurants.

Senator Coats [continuing.] —5 percent of payroll—that implies that you are not doing your fair share, and Ford is doing more than their fair share; that Ford's plan is four times better than your plan, and that you do not care about your employees because you are only paying 5 percent of your payroll to cover your employees.

But it might also mean that you are doing a heck of a lot better job at cost containment, that you have some innovative programs that are providing incentives to your employees, whereas Ford does not.

Doesn't Ford basically provide first-dollar coverage for all its employees?

Mr. PESTILLO. But Senator, that is a most misleading number, because one has to look at the total population covered. If one had a large number——

Senator COATS. So you have a lot of early retirees that you are paying for.

Mr. PESTILLO. We have 125,000 retirees of all ages. That is a significant factor. Almost half my population is retired. We have not had dramatic growth in our business.

Senator COATS. But do you provide first-dollar coverage, essentially?

Mr. PESTILLO. Yes, essentially.

Senator COATS. So there is not a whole lot of incentive to control utilization cost if it is first-dollar coverage.

Mr. PESTILLO. No, on the contrary. We work very aggressively at controlling cost.

Senator COATS. OK. What does General Mills do to try to hold down unnecessary utilization?

Mr. PEEL. The vast majority of our employees contribute to their health care coverage, and there are deductibles and other provisions in the plan that disincent excessive utilization.

Senator COATS. So there are incentives for wellness and disincentives for misuse. I do not see how the big three have that. I was just at the GM plant last week in Fort Wayne, and they said the only thing they require of their employees is a 35-cent payment for each prescription. I think most of us can come up with 35 cents. I mean, that takes the consumer totally out of the picture in terms of asking the druggist how much does this cost, is there a generic, is there a substitute, or "Gosh, Doctor, this costs a lot of money. Is there anything else I can do here?"

If all I have to come up with is 35 cents, and the company pays first dollar on everything—isn't that part of your problem?

Mr. PESTILLO. Well, not as substantially as you suggest, Senator. I do not think economic considerations weigh heavily on one's mind when making health care determinations. I think we look for the best care we can get.

Senator COATS. Well, maybe you ought to look at what General Mills is doing.

Mr. PESTILLO. Indeed, we do.

Senator COATS. Why don't you implement what they are doing? I mean, gosh, they have got—or is it all the retirees? If it is all the retiree program, I understand that. You are in significant downsizing now. In that regard, if the administration is going to pick up 80 percent of your early retirement, if I were a 55-year-old worker at Ford, I would be real nervous about my job security, because the natural tendency is to say, well, if we are going to lay people off—and the big three have been doing that, and I understand why they need to do that—I am going to lay off somebody who is between 55 and 64, because the Government is going to pick up 80 percent of their health care costs, and if it is 20 percent of my payroll, I do not see what job security your 55-to-64-year-old people have at all under this plan.

Mr. PESTILLO. Senator, other parts of the law prevent that choice on our part.

The CHAIRMAN. Mr. Peel, how many retirees do you pick up?

Mr. PEEL. We have a much smaller retiree population than Ford Motor Company does, to be sure.

Senator COATS. Oh, I understand that is a significant part of the difference, but I do think the utilization of the incentives and disincentives—we have proven that with first-dollar coverage, it is just human nature that if someone else is paying for it, you use it.

Thank you, Mr. Chairman.

The CHAIRMAN. I would just mention that we have about 32 million people eligible for retiree benefits; more and more companies are cutting back or altogether terminating retiree coverage. Whether they have legal cause or not. But to do so depends on the nature of the contract that is going right up through the roof at the present time, with companies just axing out all of these individuals in terms of bottom-line costs.

I think we are seeing more and more of that, leaving people hung out to dry.

Senator GREGG. But Mr. Chairman, doesn't that raise the secondary issue which I think is critical, and I hope we can get to it here, and maybe we could have somebody come in and testify on it, and that is the hard numbers on just how much this early retiree situation going to cost?

I notice that Mr. Magaziner has upped the number, but as you say, it is an area where there is a lot of activity right now in the area of people being cut off, which is not right, obviously; but also this woodwork effect, if you want to use that term, which Senator Coats has referred to, which probably would not affect the big three, because they are union contracts, but certainly might affect a lot of others.

So I think that getting a hard number on that issue is going to be something we should concentrate on.

The CHAIRMAN. I could not agree with you more, and we will certainly address it.

I want to thank all of you very much. Your testimony has been very helpful.

Our next panel illustrates the diversity of opinion on the part of the small business community and poses many issues that Congress needs to consider.

Robert Patricelli represents the U.S. Chamber of Commerce; he is chairman of the health and employee benefits committee and is CEO of Value Health Incorporated in Avon, CT.

Michael Roush represents the National Federation of Independent Business, where he is director of Federal and Government relations for the Senate.

William Lindsay represents National Small Business United. He is president of the Lindsay-Sandbak Group in Englewood, CO.

And Helen Mills is a founder and a board member of Business for Social Responsibility and is president of Soapbox Trading.

Senator Dodd had planned to be here this morning. The hearing was originally scheduled for next week, but the date was changed, so he was unable to adjust his schedule, but he wanted to extend a warm welcome to Robert Patricelli.

We will also include a written statement from Senator Dodd in the record as if read.

[The prepared statement of Senator Dodd follows:]

PREPARED STATEMENT OF SENATOR DODD

Mr. Chairman, thank you for holding today's hearing on the views of American businesses and workers, two groups that are critical to the well being of our economy and our society. I believe that we have reached our current need to enact health care reform legislation, in part, because businesses and workers bear so much of the burden of today's health care crisis.

Problems for business

The cards are currently stacked against business that offer health care coverage for their employees. Those that provide coverage not only face increasing costs, they also indirectly pay for the

37 million uninsured and underinsured Americans in this country. Cost shifting increases premiums by as much as 20 percent.

Rising health care costs have placed an enormous financial burden on business. Average annual health care costs per employee for businesses have risen from $1,465 in 1984 to nearly $4,000 per employee in 1992. In my own State of Connecticut, the health care payments of businesses have increased 253 percent in the last ten years.

An even more shocking figure is the $26 million per hour that American businesses spend in total on health care—this averages out to $225 billion per year. It is no wonder that eight out of ten new companies created each year do not offer health benefits to their employees.

Health care costs have cut seriously into business profits and have put U.S. business at a competitive disadvantage. Health care costs of businesses are almost equal to their after-tax profits. Back in 1980, 41.2% of after-tax profits were allocated toward health care coverage for employees. In 1991, this percentage had skyrocketed to 97.5% of after-tax profits! Health care costs have clearly reached an unreasonable level.

The increasing cost of health care hurts U.S. competitiveness. U.S. automakers spend more on health care than on steel. Even more compelling, the price of a car made in the U.S. includes $1,100 in health care costs. $1,100 per car for health care when the Japanese pay only $550 per car for health care.

Small businesses

Small businesses are hit the hardest by the cost of health care. Those companies with fewer than 25 employees pay premiums that are one third higher on average than large businesses. And these rates increase 50% faster than those of big companies.

Although 62 percent of small businesses provide their workers with coverage, many cannot afford to operate under such a financial strain. This reality must change because other businesses that provide coverage end up picking up the cost for those without coverage. We must aim to make coverage affordable so that small and big business alike can operate profitably and contribute to their employees health care coverage.

I am delighted that Robert Patricelli of Avon, CT will testify this morning on behalf of the U.S. Chamber of Commerce. He brings to the committee the perspective of small businesses which have encountered first hand difficulty securing affordable coverage and also have legitimate concerns about the impact of reform. I think we all agree that health care reform should lessen the obstacles faced by small businesses.

Problems for workers

Just as businesses are affected by the health care crisis, workers face an incredible burden as well—the burden of high premiums, job insecurity, "job-lock," and worse yet, the fear and anxiety of becoming uninsured.

Health care costs have become the number one cause of labor-management disputes in the United States. Unions have sacrificed

wage increases for health benefits. Still, an incredible 85.5% of individuals with no insurance are workers and their family members.

Those who are lucky enough to have insurance have seen their premiums rise faster than their wages during the last 15 years. The average worker could be earning $1000 more a year if this were not the case. If health care costs continue to rise at the current rate, workers will lose an additional $650 per year out of their potential wages.

On top of this reality, coverage for America's workforce is not secure. Even those who are covered by their employers run the risk of losing their job and thus losing their insurance. 37 million people in the United States do not have health insurance, and 57 million will be without insurance at some point during 1993. Also, insured workers have no guaranty that they will not lose their coverage.

Employees are often "locked in" to their jobs regardless of their job satisfaction or potential, because they rely on the coverage they receive in their current job. One out of every three Americans who earns between $30,000 and $50,000 report that they or a family member remained in jobs they would rather leave because they were afraid of losing their health insurance.

Even those who would be guaranteed another job with coverage fear changing policies because they or a dependent have a pre-existing condition which would disqualify them for a new policy. Our nation's workers have become imprisoned by their health care coverage—this reality hurts our economy and our society.

The Clinton plan aspires to reform and improve the health care system for businesses and workers by ensuring health security and controlling costs. Our goal—as we debate the details—should be to relieve business and workers of the burdens imposed under the current system. achieving this goal will benefit both our economy and our hard-working citizens.

I look forward to hearing from business and workers this morning and working with them in the coming months to achieve this end.

The CHAIRMAN. Mr. Patricelli, welcome and please proceed.

STATEMENTS OF ROBERT E. PATRICELLI, CHAIRMAN, HEALTH AND EMPLOYEE BENEFITS COMMITTEE, U.S. CHAMBER OF COMMERCE, WASHINGTON, DC; MICHAEL O. ROUSH, DIRECTOR, FEDERAL AND GOVERNMENT RELATIONS-SENATE, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, WASHINGTON, DC; WILLIAM LINDSAY, PRESIDENT, LINDSAY-SANDBAK GROUP, INC., ENGLEWOOD, CO, ON BEHALF OF NATIONAL SMALL BUSINESS UNITED; AND HELEN H. MILLS, PRESIDENT, SOAPBOX TRADING; FOUNDER AND BOARD MEMBER, BUSINESS FOR SOCIAL RESPONSIBILITY, AND MANAGING PRINCIPAL, THE MILLS GROUP, FAIRFAX, VA

Mr. PATRICELLI. Thank you, Mr. Chairman and members of the committee.

I am Bob Patricelli, chairman and CEO of Value Health, a specialty managed care company based in Avon, CT. It is a particular personal pleasure for me to be here as a witness before this committee where I was a staff member 25 years ago.

The CHAIRMAN. I remember you. Others may not, but I have warm memories.

Mr. PATRICELLI. Thank you, Senator. You and your brother had just come on the committee at the time I was a staff member.

I am here today in my role as a board member of the U.S. Chamber of Commerce and chairman of its health and employee benefits committee.

The Chamber supports national health care reform aimed at achieving universal health coverage and cost containment, and we want to see a bill passed in 1994.

We give President Clinton great credit for creating a political climate in which virtually all factions favor major health care reform. Moreover, we believe that many of the basic tenets of the Clinton plan, where they conform to the managed competition model, are correct.

Specifically and first, universal coverage which is paid for through the shared responsibility of employers, employees, and Government. Second, subsidies to help small businesses and low wage workers afford health insurance. Third, portability of coverage and elimination of medical underwriting. Fourth, pooled purchasing arrangements. Fifth, streamlining of the processing of health insurance claims. And finally, 100 percent tax deductibility of basic health insurance costs for the self-employed.

We believe health care costs can only be contained if everyone is in the system and playing by the same rules. Therefore, we accept the proposition that all employers should provide and help pay for insurance on a phased in basis over time. That way, companies now providing insurance would be freed from the cost-shifting caused by those who do not provide benefits.

But at the same time, individuals should be required to have insurance coverage, and they should help pay for it and should face sufficient cost-sharing requirements to make their use of medical services economically prudent.

We recognize that some individuals and employers are unable to afford coverage, and as we told the White House task force from the very beginning, the Chamber opposes any health insurance mandate or requirement for an overly rich, standard benefit package or one that does not include adequate subsidies for low wage workers and their employers.

While there are elements that we like in the Clinton plan, we also have very serious concerns in several areas, and let me list five such areas.

First, the regional health alliances are so large they absorb virtually the entire nonelderly population. They should instead be focused where they are needed, on small firms with less than 100 employees. And moreover, to guard against adverse selection, we strongly advise against allowing larger companies to opt into the alliance and cost-shift their costs to the small business community. Larger companies over 100 employees in size should be permitted to choose commercial insurance, to form purchasing groups among themselves, or to self-insure. These large companies, as we have just heard, have driven much of the innovation in cost containment, managed care and wellness programs, and their energy and creativity should be preserved in the health care system. Yet the

Clinton plan is full of disincentives for this kind of constructive employer role.

Second, the Clinton plan creates a vast new web of Government regulation and bureaucracy to contain health costs and oversee the operational details of the health care system. That regulation will assuredly prevent the efficient operation of a health care market, which ironically is one of the professed goals of the plan. In particular, we object to the use of Government-specified premium caps. The adoption of premium caps would freeze in place historical inefficiencies such as regional variations in practice patterns and prices and will create an annual political Donnybrook as regions and their congressmen fight over the size of their slice of the pie.

Third, there is excessive State flexibility to establish varying health care systems up to and including single-payer plans. In today's global economy, that kind of fragmentation is ill-advised.

Fourth, we object to a premium split that requires employers to pay 80 percent of the cost of an overly rich plan with low cost-sharing provisions. This insulates employees from most of the economic consequences of their own purchasing decisions. We would support a maximum premium contribution requirement of around 50 percent for employers, leaving it to their discretion to pay more. Consumers must be aware of how much health care really costs.

Fifth and last, we fear that the plan creates excessive new costs, but involves savings and revenue assumptions that could prove to be unrealistic. We honestly find it hard to believe that we can cover 37 million uninsured people, guarantee a generous benefit package to all, create new programs for prescription drug coverage for Medicare, long-term care coverage and early retiree subsidies, and finance almost all of that out of savings. We would be happy to see such major savings, but in the meantime we are wary about counting our chickens before they hatch, and we worry about what the financing fallback might prove to be.

So in conclusion, the President's plan is one of several proposals which deserve very serious consideration. The Chamber is also encouraged by the introduction of the Cooper-Grandy Managed Competition Act of 1993 in the House and by the proposal offered by Senator Chafee and colleagues in the Senate. Both are valuable additions to the debate and indeed are closer to our thinking on structure than the Clinton plan. But we think a compromise is possible, and we look forward to working with members of this committee in forging a workable bill.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Patricelli follows:]

PREPARED STATEMENT OF ROBERT E. PATRICELLI

Good morning, Mr. Chairman and members of the Committee. I am Robert E. Patricelli, Chairman and CEO of Value Health, Inc., a specialty managed care company in Avon, CT. I serve on the Board of Directors of the U.S. Chamber of Commerce, and am chairman of its Health and Employee Benefits Committee. I appreciate this opportunity to present the Chamber's views on an issue that has become almost as central to us institutionally as it is to each American personally.

As you may know, the Chamber federation includes some 3,000 local and state chambers of commerce, 1,200 trade and professional associations, 68 American Chambers of Commerce abroad, and 215,000 businesses, 96 percent of which employ fewer than 100 people. Roughly two-thirds of these small companies, and virtually

all of our larger members, currently provide some form of health insurance for their workers. In the past six years, the overall cost of health insurance for these employers has doubled. Some have been forced to cut back or drop insurance coverage, and many others fear they will have to do the same if relief from escalating costs is not forthcoming. These rapidly growing health care costs have hit small businesses particularly hard. Unlike larger companies, whose size enables them to contract with providers and insurers for discounted services, small companies pay full freight. In addition, they are burdened by unfair medical underwriting practices employed by the insurance industry, and by costs shifted by hospitals and doctors to make up for uninsured patients unable to pay their bills.

President Clinton deserves credit for moving the health care debate to center stage. As is probably inevitable in something so complex, his proposal has strengths and weaknesses. The Chamber has serious concerns about some aspects of the Clinton plan, such as:

- Regional health alliances that include most of the population instead of focusing on small business.
- A huge new bureaucracy to regulate, monitor, and ultimately tax employers.
- State flexibility to establish independent systems.
- Government-specified premium caps.
- A requirement that employers pay 80 percent of the premium for an overly rich benefit package.
- Optimistic savings assumptions coupled with excessive new federal spending.

We will elaborate on these concerns later in this testimony.

The Chamber supports the need for universal coverage and recognizes that it can only become a reality and be paid for through the shared responsibility of employers, employees, and government. This principle is reflected in the Clinton plan. In addition, some specifics of the Clinton plan consistent with Chamber policy recommendations include:

- Universal coverage.
- Subsidies to help small businesses and low-wage workers afford health insurance.
- Portability of coverage and elimination of medical underwriting.
- Streamlining the processing of health insurance claims.
- 100 percent deductibility of basic health insurance costs for the self-employed.

Chamber members recognize that employers have a critical role to play in reforming our health care system. We are in favor of a system that achieves affordable health insurance coverage by building on the strong current base of employer-provided health benefits. Our members maintain that health insurance should remain part of the compensation package. This may seem surprising in light of the small-business alarms sounded so frequently in the news. What we have found, though, is that small business views on health care policy do not necessarily follow traditional ideological lines. A study published in the September/October issue of the Journal of American Health Policy (copy attached) mentioned a variety of views within the small business community and noted that "small businessmen and women are more open to health care reform than conventional wisdom holds." Most small businesses that do not provide health insurance to employees cite high cost as the barrier. If convinced that health insurance could be made more affordable through pooled purchasing, four-fifths of small businesses surveyed would favor such a system.

Health care costs can only be contained if everyone is in the system and playing by the same rules. Therefore, we accept the proposition that all employers should provide and help pay for insurance on a phased-in basis over time. That way, companies now providing insurance would be freed from the cost-shifting caused by those that do not provide benefits. At the same time, individuals should be required to have insurance coverage and to help pay for it, and should face sufficient cost sharing requirements to make their use of medical services economically prudent.

However, we recognize that some individuals and employers are unable to afford coverage. As we told the White House task force from the very beginning, the Chamber opposes any health insurance requirement that does not include adequate subsidies for low-wage workers and their employers.

We think this is an area where the Administration listened to us. The Clinton proposal incorporates both a small-business subsidy in the form of an expenditure cap on percentage of payroll and an individual subsidy for those whose incomes are below 150 percent of the poverty level. We think these provisions would help make insurance affordable.

To elaborate on the concerns sketched earlier:

Regional health alliances that are so large they absorb virtually the entire population. The Chamber has long supported pooled purchasing arrangements (whether called alliances, or HIPCs, or whatever) for small businesses. Statistics indicate that it is among employees of small businesses that the greatest coverage gaps exist, and it is these companies that need to band together to achieve economies of scale. In this way, small businesses and individuals will finally have the leverage to compete against larger companies in the market for health insurance. Many of our smaller members eagerly welcome the idea of one-stop shopping—that they can call and get from a single source all necessary information about health care plans, prices, and quality without having to spend hours on the phone calling around to agents. These members remind us that they are in the business of selling hardware or lumber or manufacturing coolers and have neither the time nor the expertise necessary to sift through health insurance policy language to find the appropriate features and the best deal. To concentrate assistance where it is needed, the Chamber would set the ceiling for required participation in a regional alliance at 100 employees. To guard against adverse selection, we would advise against allowing large companies to opt into the alliance.

Larger companies should be permitted to choose commercial insurance, form purchasing groups among themselves, or self-insure. Large self-insured companies have driven much of the innovation in cost containment, managed care, and wellness programs. We believe that their energy and creativity should be preserved in our health care system. If such companies no longer are able to reap the cost savings from improving their group experience, there is little incentive for them to continue to develop and maintain such programs. Large companies community rate their employees, and do not discriminate on the basis of health status. Reform should focus on the parts of the system that don't work—not the parts that do work.

Over-reliance on government regulation and bureaucracy to contain health care costs and oversee the operational details of the health care system. The Clinton plan would vest substantial regulatory power in a new National Health Board, granting it authority for tasks ranging from modifying the guaranteed benefit package to setting the national health care budget to disciplining alliances and states that fail to meet budget targets. Such a weight of federal oversight is bound to hamper efficient operation of the market, and is counter to a professed intent to streamline the health care bureaucracy that already exists.

State flexibility to establish separate health care systems. In today's competitive global economy, such fragmentation is ill-advised. Multi-state companies potentially will be forced to squander resources on complying with 50 different sets of rules at a time when American companies need to focus on improving productivity to meet foreign competition. To help states go their own ways, the Clinton proposal makes a series of changes to the Employee Retirement Income Security Act of 1974 (ERISA) that would vitiate the preemption provisions at its very center. We recognize that achieving universal coverage will require some modification of ERISA—for example, through application of a minimum standard benefit package. But any ERISA changes should continue to permit self-insured plans to rely on a single federal regulatory standard; indeed, that standard was what led employers to support ERISA at the time of its enactment.

Government-specified premium caps, rather than market forces, setting the rate at which health insurance premiums could increase. A properly functioning market is a more efficient resource allocator than a government agency. The adoption of premium caps would freeze in place historical inefficiencies, such as regional variation in practice patterns and pricing. For example, Mrs. Clinton has noted that average per-patient Medicare costs in the Boston area are twice as high as those in New Haven, without any discernable difference in overall patient well-being.

A premium split that places a disproportionate burden on employers. Requiring employers to pay 80 percent of the health insurance premium insulates employees from the consequences of their own purchasing decisions. We would support a minimum premium contribution of 50 percent for employers, leaving it to their discretion to pay more. Consumers need to be aware of how much health care really costs. We also question basing the required payment on the weighted average premium in a regional alliance. Given that all plans would have to offer the guaranteed benefit package, consumers could be encouraged to choose less expensive plans if the employer contribution were pegged to the average of the lower third or half of plans in the alliance.

Savings and revenue assumptions that could prove to be unrealistic. Expanding coverage to bring in an estimated 37 million uninsured at the same time that we guarantee a generous benefit package to all, provide the elderly with prescription drug coverage, create a new long-term care benefit, and subsidize coverage to early retirees cannot help but be an expensive proposition. It may be that efficiencies can

be realized, fraud and abuse curtailed, and wages and profits increased (reflecting health cost savings), thus generating higher tax revenues. The Chamber would be happy to see such results. In the meantime, however, we are wary of counting our chickens before they hatch, and worry about what the financing fall-back might prove to be.

One of the reasons for the President's commitment to health care reform is his desire to bring the federal deficit under control. Since this cannot occur without constraining costs in federal entitlement programs, the Chamber believes that Medicare and Medicaid must be included in reform measures. As people reach Medicare eligibility, we foresee their choosing to remain in their existing care networks rather than disrupting their physician relationships to move to a wholly separate, artificially preserved government program. We support the Clinton Administration's decision that Medicaid beneficiaries should be brought into the reform mainstream immediately, obtaining coverage through a purchasing cooperative like any other individuals, but with government assistance to pay the premiums. We also agree that the Medicaid population should be pooled separately for premium purposes, so that small businesses participating in the cooperative are not put in the position of subsidizing the relatively sicker Medicaid population.

Medical malpractice reform is a necessary component of health care reform. The President's proposal includes provisions meant to address this concern, but it does not go far enough to produce real changes in the way physicians practice medicine. So long as doctors still feel the need to practice defensive medicine, serious savings in this area will not be realized.

The Chamber recognizes, as do President and Mrs. Clinton, that this proposal is by no means immutable. It represents the beginning of serious debate and of a public education program. The Chamber is heartened by an emergence of some common themes among a broad spectrum of reform proponents. These themes include portability of coverage, an end to pre-existing condition exclusions, administrative streamlining, and 100 percent deductibility of health insurance costs for the self-employed.

The President's health care plan is one of several proposals which deserve serious consideration. The Chamber is encouraged by the introduction of the Managed Competition Act of 1993 in the House and by the proposal offered by Senator Chafee and colleagues; both are valuable additions to the debate. The Chamber will continue to play a constructive role in the formation of national health care policy by advocating the concerns of the business community as we work to forge a national consensus and enact legislation. We look forward to working with the members of this Committee in that process.

Small Businesses' Changing Views on Health Reform

Our national sample of 750 randomly chosen firms with fewer than 50 employees reveals surprising findings about the traditional views of small business on health care reform. A substantial segment of the small business community is sympathetic to health care reform, including such controversial measures as mandating that all employers contribute to the coverage of their workers, limits on health care spending, and altering the tax treatment of employer contributions for health insurance. Without premium savings, fewer than half of small businesses support the concept of health insurance purchasing cooperatives. With premium savings, a majority support it.

By Gail A. Jensen, Robert J. Morlock, and Jon R. Gabel

In the Clinton Administration's quest for comprehensive health care reform, few interests will exert greater influence through the political process than small business. Because Americans tend to romanticize small businesses, the small business lobby — along with the elderly — is one of the most influential interest groups in Washington. Small business is also seen as the engine of economic growth. Between 1982 and 1990, two-thirds of the new jobs created were in the small business sector (Kent, 1993).

The dilemma facing policymakers is that the same small businesses that fuel economic growth are also where an estimated 50 percent of the nation's 36 million uninsured Americans work (Congressional Budget Office, 1991). The Health Insurance Association of America found, in their national survey of employers, that fewer than 30 percent of firms with 10 or fewer workers offer health insurance to their employees (Lippert and Wicks, 1991). To achieve universal coverage, preliminary versions of the Administration's reform package call for mandatory contributions by all employers toward the cost of health coverage for their employees. Small employers would send their contributions to a health insurance purchasing cooperative (HIPC, also termed health alliance) where their employees would select from a menu of accountable health plans.

The small business lobby, as represented by the National Federation of Independent Businesses (NFIB), is adamantly opposed to the Administration's reform package. For example, NFIB refused a White House invitation to appear on a small business panel for a March 29, 1993, health care task force meeting. Yet the views of the small business community are diverse and occasionally deviate from those of the small business political lobby.

Using a national survey of 750 firms with fewer than 50 workers conducted in the spring of 1993, we examined the views of the small business community on current proposals for health care reform. Small business owners were asked about the need for reform of the health care system, their views about the fairest way to treat employer contributions to health benefits under the tax code, and how they felt about the basic principle of requiring all employers to contribute to the cost of health insurance. Our findings suggest a variety of views within the small business community and that small businessmen and women are more open to health care reform than conventional wisdom holds.

Methods

In April and May 1993 the survey research firm National Research Inc. of Washington DC conducted telephone interviews with 750 small businesses nationwide.

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The sample was drawn from the Dun & Bradstreet Corp. (D&B) list of private businesses nationwide that employ fewer than 50 workers. Survey participants were drawn randomly from D&B's list after stratifying by size and location. The sample excluded businesses with no employees and government employers. In advance of the interview, business owners were sent a letter inviting them to participate in the study and indicating when they would be contacted for their interview. At the time of the survey, the interviewer asked to speak with the person most knowledgeable about the fringe benefits the business offered. In most cases that person was the owner, president, or office manager of the firm. In all, 1,721 firms were contacted, and 750 agreed to participate in the survey. This response rate of 44 percent is typical of small business surveys.

Reflecting the probability of selection, each employer was assigned a weight. This allowed us to calculate national statistics representing all private businesses employing fewer than 50 workers. The margin of error on estimates from the survey is approximately plus or minus four percentage points.

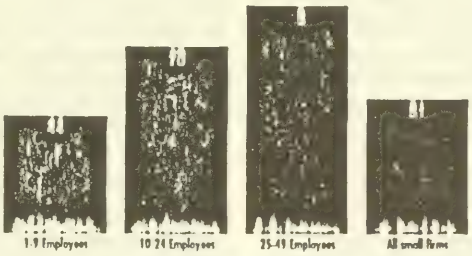
Size Determines Coverage

We found that 50 percent of all businesses with fewer than 50 workers do not offer health benefits as a fringe benefit. The size of a business, as measured by the number of people it employs, is the single most important predictor of whether it provides health insurance. The larger the firm, the more likely it is to provide coverage.

Our survey found that the percentage of firms offering health insurance is 44 percent among firms employing fewer than 10 workers, 70 percent among firms employing 10 to 24 workers, and 85 percent among firms employing 25 to 49 workers (see Figure 1). Among all firms with fewer than 50 workers, the low overall percentage offering coverage — 51 percent — reflects the fact that the vast majority of firms in this size range employ fewer than 10 workers.

Figure 1

The Percentage of Small Firms That Offer Health Insurance by Size of Firm, 1993



Source: Wayne State University/KPMG Peat Marwick, Survey of 750 Small Firms, Spring 1993.

Reasons Against Coverage

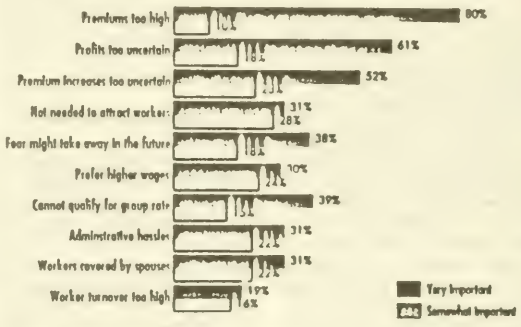
Our survey asked firms that do not provide health insurance to indicate why. The most frequent response was that current premiums were simply too high. Eighty percent of small businesses indicated that high premiums were a "very important" factor in the decision not to provide benefits, and another 10 percent indicated that they were a "somewhat important" reason (see Figure 2). Other often cited reasons for not offering insurance were that the firm's profits (79 percent) and/or premiums for insurance (75 percent) were too uncertain from year to year to make a commitment to provide health benefits.

Our survey reveals that most small businesses maintain a high degree of continuity in their insurance offerings. We found that many firms (56 percent) that chose not to offer insurance feared that if they did provide it, they might have to take it away at some future date. It was unusual to find firms that did not provide insurance at the time of our survey had ever provided it. Only 17 percent indicated that they had. Likewise, nearly all firms (89 percent) offering insurance at the time of our survey had offered it for at least the past three years. These findings of a high degree of stability in the insurance offerings of small businesses confirm the findings of earlier surveys on this issue (Lichtenstein and Witte, 1991). Many small businesses, and

particularly those with fewer than 10 employees, report that qualifying for a policy at group rates is often difficult. Thirty-nine percent of the firms not offering insurance reported that their inability to qualify for coverage at employer rates was a very important reason for not offering coverage. Yet when asked why they were unable to qualify, only about half could give a specific reason. The three explanations, identified with roughly equal frequency, were: the firm was too newly established; the type of business or industry the firm made it ineligible for a policy; or one or more employees could not qualify for insurance because of health conditions.

Figure 2

Why Small Firms Say They Don't Offer Health Insurance



Source: Wayne State University/KPMG Peat Marwick, Survey of 750 Small Firms, Spring 1993

Desire for Reform

Participants in the survey were asked their opinions about some potential reforms of the health care system. Regardless of whether they provide health coverage, most small businesses (75 percent) say they favor a major restructuring of the health care system, 11 percent are opposed to major changes, and the rest gave no opinion. Support for major changes in the system, however, is not synonymous with support for any one particular reform strategy.

To assess the direction in which small business owners felt public policy should go, we asked respondents to comment on the appropriateness of several possible reforms to the health care system. Specifically, we asked them how they felt about: (1) requiring all employers to contribute toward the cost of health insurance for their employees; (2) imposing overall limits or budgets for health care spending; (3) changing the tax treatment of employer contributions for health insurance; and (4) adopting a "managed competition" model for securing workers' coverage rather than a direct employer provision model.

To elicit their views on the first issue — the desirability of mandating that employers contribute to the cost of health insurance — the interviewer said, "Some employers are concerned about proposed legislation that would mandate all employers to provide or contribute to the costs of health benefits for their employees. Others contend that a mandate is the only fair way to see that everyone has health insurance, and that when Employer *A* doesn't provide coverage, other employers indirectly pay for the coverage of *A*'s workers. How do you feel about requiring all employers to contribute for the coverage of their employees?"

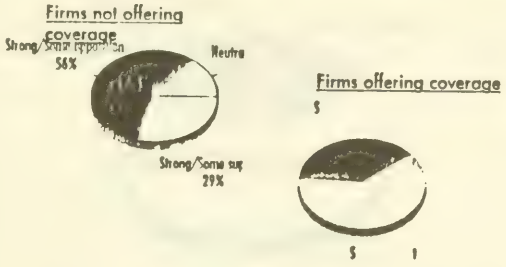
We wanted the respondent's opinion after he or she had heard at least part of the rationale for such a requirement. Small business owners were then asked to indicate whether they strongly support mandated contributions, somewhat support them, are neutral, somewhat oppose, or strongly oppose them.

Our survey found that close to half (42 percent) of all small businesses support the principle that employers should be required to contribute to the cost of health insurance for their employees. Even among firms not currently offering insurance, close to one-third (29 percent) say they support such a requirement. Among firms now providing coverage, 51 percent favor mandated contributions (see Figure 3).

This level of support for a mandate is much higher than earlier surveys of small businesses have found. For example, a 1989 survey of member firms of the NFIB found

Figure 3

Small Firms Offering Health Coverage Have Different Attitudes About Mandated Coverage Than Firms Declining Coverage



Source: Wayne State University/KPMG Peat Marwick, Survey of 750 Small Firms, Spring 1993

that only 25 percent agreed that "employers have a responsibility to provide employee health insurance," and only 24 percent supported the statement that "employers should be required to provide a basic level of employee health insurance" (Hall and Kuder, 1990). Respondents to the NFIB survey were overwhelmingly small firms, and, at least in terms of their size and industry composition, were similar to the firms covered by our survey.

It is possible that the increased support for a mandate may stem from our questionnaire's format. Unlike previous opinion surveys of small business, our survey attempted to give the respondent information on the case for various reforms. After hearing the argument for the proposition in question, business owners may have been more likely to support it as reasonable. It is also conceivable that the particular argument for a mandate that we chose to present — that firms not offering coverage end up as free-riders to the health care system — evoked either a sense of guilt or disturbance among some respondents. This might explain why so many (29 percent) of the firms that currently do not offer coverage essentially favor what amounts to a new requirement and cost for them.

On the issue of imposing overall budget limits for health care spending, respondents were simply asked to indicate whether they strongly support such measures, somewhat support them, are neutral, somewhat oppose, or strongly oppose them. Many small business owners (66 percent) indicate that they would like to see overall limits or budgets for health care spending imposed as part of a health care reform strategy. Firms that want a major restructuring of the health care system are most likely to support this particular reform.

To assess business owners' opinions about changing the current tax treatment of health insurance, we took a different approach. We asked small business owners which of three approaches they thought would be the "fairest" way to treat employer contributions for health coverage: (1) "treat all employer contributions for health insurance as tax-free, as they are today"; (2) "tax employer contributions for health insurance the same as wage income"; or (3) "treat employer contributions as tax-free up to the lowest cost plan in an area." Before giving them these choices, however, the interviewer said, "Currently, employers' contributions for health insurance are not treated as taxable income of employees. Some economists contend that this encourages Americans to over-insure and choose Cadillac health plans. Others say that taxing workers for employers' contributions for health insurance would place a greater burden on the middle class. Which of the following is the fairest way to treat employers' contributions for health coverage?"

As with our previous question about required contributions, we wanted to obtain business owners' opinions about changing the tax code after they had heard at least part of the case for reform.

Only a slim majority (60 percent) of small businesses believe that maintaining the status quo is the fairest approach to taxation (see Figure 4). Fifty-two percent of firms that do not now offer coverage believe that the current tax-free status of all employer

contributions to health benefits should be preserved; among firms that offer insurance a slightly higher percentage, 65 percent, believe so. Just over a quarter of businesses (26 percent overall) believe a tax cap on employer contributions is fairest. A small minority (9 percent), concentrated largely among firms that do not now offer insurance, believe that employer contributions for health insurance should be treated the same as wage income.

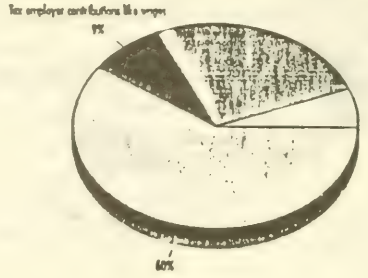
Managed Competition Views

On the matter of managed competition as a model for health care reform, we asked small business owners to indicate which of two approaches they would prefer if they were required to contribute to the cost of workers' health insurance. The choices described were providing group health insurance directly themselves, or contributing to the cost of securing workers' insurance through a HIPC.

The HIPC system that small businesses were asked to consider was described as entailing the creation of new statewide purchasing cooperatives specifically for firms in their size class (fewer than 50 workers). Employers would be required to pay a contribution on behalf of each of their workers, which would be used toward the lowest-cost certified plan in their area. That contribution would then buy an employees' health insurance through the local HIPC, which would offer a wide choice of health plans to employees and would relieve small businesses of having to administer benefits themselves. Survey respondents were asked if they would prefer to pay the contribution to a HIPC or to provide group insurance themselves. The firms were also asked what price incentives would cause them to prefer the HIPC model to providing the insurance themselves.

Figure 4

Almost Half of All Small Firms Are Willing To Change the Tax Treatment of Employer Contributions to Health Insurance



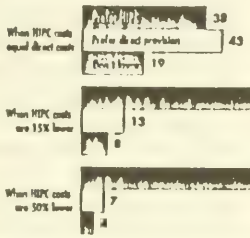
Note: Percentages do not sum to 100 due to rounding.
Source: Wayne State University/KPMG Peat Marwick Survey of 750 Small Firms, Spring 1993.

Small business owners' attitudes toward managed competition depend critically on the perceived savings associated with that approach. If a required HIPC contribution will cost firms the same amount as if they purchased health insurance for their employees directly, then most small businesses (61 percent) are unwilling to endorse a HIPC system (see Figure 5). In this case, 43 percent prefer providing health benefits themselves, and 19 percent say they "don't know" which approach they prefer. Firms not now offering insurance are much more supportive of HIPCs than firms currently providing benefits, yet fewer than half of them endorse the concept (46 percent favor HIPCs compared to 32 percent among firms offering coverage).

If HIPCs can save small businesses money, however, then support for them is actually very strong. Four-fifths (79 percent) say that they would favor a HIPC-type system if it can save them 15 percent over providing insurance directly. Thirteen percent say that they would prefer to provide health insurance themselves, and the rest (8 percent) say they "don't know." If HIPCs can save businesses 50 percent over the cost of direct provision, then nearly all firms (90 percent) endorse them. Interestingly, most of the firms that changed their opinion of HIPCs when the relative price was lowered were

Figure 5

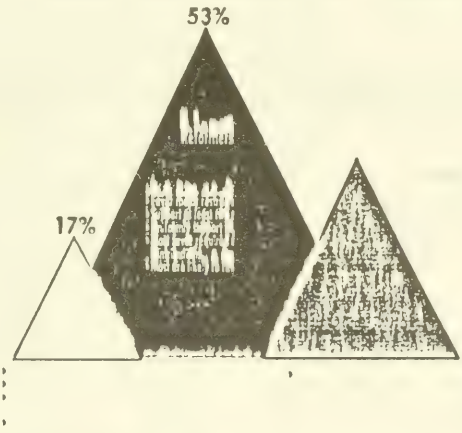
Under What Circumstances Will Small Firms Support HIPC-Style "Managed Competition" Over Direct Provision



Note. Percentages may not sum to 100 due to rounding.
Source. Wayne State University/KPMG Peat Marwick Survey of 750 Small Firms, Spring 1993.

Figure 6

Political Subgroups Among Small Business



Source. Wayne State University/KPMG Peat Marwick Survey of 750 Small Firms, Spring 1993.

firms that currently provide benefits. The fact that they reversed their preferences so readily reflects the obvious importance they place on saving money on health insurance. Lowering their costs is their primary goal, and if HIPCs can take them there, they will support them.

For our initial HIPC question (about preferences if the employer's costs under both approaches were the same) the high percentage of small businesses that say they "don't know" which they prefer (19 percent) suggests that many of them still don't understand how a managed competition system would work, and they may not understand the full implications of it for their business. Even without such an understanding, however, we found that many of them converted to supporting a HIPC system when they perceived savings under that approach.

These findings convey two messages. First, policymakers will need to carefully explain alternative reform proposals if they wish to elicit the true preferences of small businesses. Second, the overriding concern of small businesses is to save money on the cost of insurance.

Political Subgroups

The above discussion suggests that there is considerable diversity among small businesses in their opinions of various reforms. Although characterizing firm views on a reform-by-reform basis is useful for summary purposes, examining the data in that way does not tell us whether there are certain sets of opinions that tend to go together. For example, do firms that express opposition to one measure also tend to reject

other reforms, or is there any congruence in responses? Alternatively, to what extent do supporters of change in one area overlap the supporters of change in other areas?

We examined our data to determine whether there was a natural segregation of small businesses according to their opinions on the four policy issues discussed in the prior section. Within the small business population, we were able to identify three distinct subgroups of firms: (1) those that support several of the reforms we had them consider, (2) those who oppose almost all of them, and (3) those who are somewhere between these two camps.

The first group, who can be described succinctly as "reformers," consists of firms that say they want a major restructuring of the health care system and who then back up that position by supporting change in at least two specific areas. Just over half (53 percent) of all small businesses are reformers by these criteria (see Figure 6). They uniformly support global limits on health care spending (91 percent), and most (62 percent) also believe that employers should be required to contribute to the cost of health insurance. They are split, however, in their views on changing the tax code and on the desirability of HIPCs. Fifty-five and 58 percent of reformers, respectively, favor these two possible reforms. As a group, reformers encompass all sizes and types of firms. Indeed, their composition closely mirrors the general population of small businesses.

The second group are best described as "defenders of the status quo." They are small businesses that say they oppose any restructuring of the system and who then go on to reject (perhaps not surprisingly) all, or all but one, of the specific reforms we discussed. They comprise nearly one-fifth (17 percent) of all small businesses. If defenders are willing to support anything, it is almost always changing the current tax treatment of employer contributions for health insurance. Twenty-two percent of defenders do not consider the current tax treatment to be the fairest approach to taxation, but many of them are still undecided as to the best alternative. Firms with more than 10 workers, and those offer-

Figure 7

Support for HIPC-Style "Managed Competition" Varies Sharply by Political Subgroup

Question	Reformer Group	Defender Group	Betwixted Group
Suppose the required HIPC contribution for employee health insurance were to cost you the same as if you purchased health insurance for your employees directly. Which would you prefer: to pay a contribution to a HIPC or provide the group insurance directly yourself?			
Prefer to pay the required HIPC contribution	58	8	20
Prefer to provide group insurance though the firm	27	62	61
Don't know	15	30	19
What if the required HIPC contribution were to cost your firm 15% less?			
Prefer to pay the required HIPC contribution	87	47	79
Prefer to provide group insurance though the firm	7	34	12
Don't know	4	19	9
What if the HIPC contribution were to cost your firm 50% less?			
Prefer to pay the required HIPC contribution	96	69	90
Prefer to provide group insurance though the firm	3	22	5
Don't know	1	9	5

Source: Wayne State University/KPMG Peat Marwick Survey of 750 Small Firms, Spring 1993.

ing health insurance, are most likely to defend the status quo. Not surprisingly, defenders are more than twice as likely as reformers to reject HIPCs as a means of providing coverage (62 percent compared to 27 percent favor direct provision) (see Figure 7). Their attitude toward HIPCs is consistent with their rejection of the other reforms that were presented to them.

The third group, which accounts for 30 percent of small businesses, are firms that do not fit either of these profiles. We call them the "betwixted" group. They are typically firms that say they want major restructuring of the health care system, but yet they reject the specific reforms we offered them. Obviously, these firms are frustrated with the current system. Their failure to embrace the measures we described, however, could be interpreted a number of ways. They may favor some particular reform not discussed during the interview, or they may simply not know what they want. For example, we neglected to ask about support for a single payer all-government system, yet reportedly many small businesses favor this approach to providing universal access (Edwards et al., 1992). Our omission of this alternative is a limitation of our survey. Also, since the reforms that we did discuss with them could entail eventual costs to either firms or individuals (some nonpecuniary), respondents who perceived these costs might have rejected the measures on that basis. While conceivable, we think this possibility is less likely than the first two mentioned. Nonetheless, we can only speculate on the reasons for this rejection of specific reforms by firms that say they want change.

The opinions of small business on national health care reform have changed profoundly over the past few years. It is no longer true that small businesses are unified in opposition to an all-employer mandate. Today, 42 percent of small businesses agree that employers should be required to contribute to the cost of health insurance for their employees. Yet as recently as 1989, only 24 percent of small business owners lent their support to a statement that employers should be required to provide basic health insurance for their workers (Hall and Kuder, 1990).

The common view that small businesses are unwilling to reduce the current tax subsidy for employer contributions to health insurance is inaccurate as well, based on this survey. Today, only a slim majority believe that maintaining the status quo is the fairest approach to the taxation of health benefits. Forty percent of small business owners either favor a reduction in the current tax subsidy for employer contributions or are undecided on this issue. Among firms that reject the status quo, most believe that a limit should be placed on the amount of employer contributions counted as nontaxable income to employees. They favor a tax cap set at the level of the least costly plan in a firm's local area.

A Heterogeneous Group

This survey also tells us that while their opinions are changing, small businesses today are quite heterogeneous in their attitudes toward health care reform. While there are many firms that endorsed several specific policy reforms touched on in the survey, there are others that repeatedly rejected the possible reforms described to them, and still other firms that said they wanted major reform but then were unwilling to support specific strategies. In 1993, the first group is by far the largest, comprising 53 percent of all small businesses. Each of the reforms discussed in our survey was endorsed by a majority of these "reformers." In order of preference, reformers favor overall budget limits for health care spending, a mandate that employers contribute toward the cost of health insurance, a HIPC system for small business health insurance, and changes in the current tax treatment of employer contributions for health insurance.

The cost of health insurance is an overarching concern of small businesses. Our survey found that cost was the most frequent reason given for not offering coverage, and it was also pivotal in influencing small business owners' support for managed competition. If insurance purchasing cooperatives can deliver savings on the order of 15 percent, then small firms overwhelmingly favor securing workers' coverage through such purchasing arrangements rather than directly providing insurance themselves. Absent such savings, however, only a minority of small businesses endorse the managed competition model. Our survey also suggests that many small firms still don't understand how managed competition would work, so policymakers need to educate this group if they want to elicit their true preferences on this issue.

Small businesses may now be a more potent force for national

health care reform than they were just a few years ago. Not only do firms say they want major restructuring of the health care system, but most are now willing to endorse specific changes in policy. This is new. Although still a collective minority, many small businesses are even willing to support reforms which entail obvious costs to themselves or to their employees.

Small business should not be viewed as a roadblock to reform, but rather as a group that needs to be educated. Our survey shows that when presented with both sides of the case for reform, many businesses are willing to sacrifice for the greater goal of achieving positive change in the system. ☆

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The CHAIRMAN. Mr. Roush.

Mr. ROUSH. Mr. Chairman, members of the committee, the National Federation of Independent Business is a small business advocacy organization that represents some 610,000 small businesspeople across the country. Our average member has about seven employees, and our members set our position. On behalf of those members, I am extremely pleased to be here this morning because this committee is addressing the number one problem of small businesses in this country, and that is the cost of health insurance for their employees.

For small businesses, at least for our members, the status quo is not acceptable, and they want the system to be changed.

In order to judge the impact of any reform package and to understand why our members support the kinds of reforms that they do, it is important to have at least a little bit of an idea of the composition of the business community and some demographic characteristics of business owners in general.

So very briefly, there are about 5 million employers in this country. Of that number, only 15,000 employ more than 500 people; that is .3 percent. On the other end of the scale, 60 percent of the employers in this country employ one to four people. In fact, nine out of ten employers in this country employ less than 20 people.

As far as the small business owners themselves, they have obviously all kinds of characteristics, but some generalities do hold. Most got into business with their own personal or family savings. One-half of all the new businesses that are started in this country are started with less than $20,000. One in five businesses that are started in this country is started with less than $5,000. Ten percent of all business owners in this country earn $10,000 or less. When you are starting a business, for the first few years of starting a business, that number is one-quarter of all the new businesses earn $10,000 or less for the first year or two.

These kinds of businesses are surviving on cash flow as opposed to profitability in many cases, just getting from payroll to payroll. But nevertheless, 800,000 to 900,000 of those kinds of businesses start each year, and in doing so, they create about one-third of all of the net new jobs in any given period that are created in this economy.

Unfortunately, one-half of those 800,000 to 900,000 new start-up businesses, or the owners of those businesses, will be out of business in 5 years. The survival rate is not terrific. And if one of those business owners is providing health insurance to his employees, he is struggling to pay for it, and he wants the system to change. And if he is not providing health insurance to his employees, as about one-half of them do not, he is also struggling, and he really wants the system to change because he wants health insurance.

In general what our members are telling us is that they want the costs to come down; they want a major reform that brings the cost of health insurance down. Particularly what they are saying is that they want insurance reforms that many people have spoken of, guaranteed renewability, portability, elimination of pre-existing conditions, modified community rating. They also tell us that they would like to see legislation that would encourage the creation of

purchasing coops or purchasing groups so they can exercise the same kind of negotiating power that larger corporations now enjoy.

They would like to see self-employed individuals be able to deduct 100 percent of the cost of their health insurance, as corporations can currently do. They would like to see the creation of an affordable, basic, essential care health insurance package and have it required to be offered to them.

They would like to see the malpractice law reformed. They would like to see State-mandated coverage laws and anti-managed care laws preempted. They would like to, like everybody, ensure that administrative and paperwork savings are ensured and brought into the system. And they would like to have requirements in the law that consumer information be much more readily available and in language that they can understand.

So the NFIB, despite what Senator Metzenbaum might have thought, is looking forward to working with you and other members of the Senate and the Congress to bring about major health care reform in this Congress and thereby relieve small businesses of their number one problem.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Roush follows:]

PREPARED STATEMENT OF MICHAEL O. ROUSH

Thank you for this opportunity to testify before the Senate Labor and Human Resources on the important subject of health care reform. We appreciate the opportunity to share the views of the National Federation of Independent Business. NFIB has accumulated much information over the course of a decade of research and communications on the health insurance needs of the small business community and what they would like to see in a reform package. NFIB is the nation's largest small business advocacy organization, representing more than 600,000 small and independent busihess owners nationwide. NFIB's positions on legislative issues are established by its members.

BACKGROUND

Health insurance was first cited as the number one problem for small business owners in a 1986 NFIB Foundation survey, Problems and Irriorities. Since that time, the cost of health insurance has been rated the number one small business problem. In recent years, it has become twice as critical as the number two problem, "federal taxes on business income." For this reason, reform of the nation's health care system has become NFIB's top issue priority.

NFIB Foundation surveys found that small business owners view health insurance as the top fringe benefit they make available to their employees, both out of a sense of familial obligation and competitive necessity. According to NFIB studies, firms that provide insurance tend to be the more stable, mature, more profitable firms, and have more full time employees than their counterparts that do not offer insurance. NFIB's members tend to be more stable and mature than the general small business community. A larger percentage of them (nearly two-thirds) provide health insurance as a fringe benefit than does the general small business community. Of the firms that do not offer health insurance, most say they would do so if they could afford it.

SMALL BUSINESS AND HEALTH INSURANCE COVERAGE

The question of how many employers are currently providing health insurance should be important to all those who are committed to reforming the system because the President's proposal will require an employers who do not currently provide insurance to spend at least 3.5% of payroll to pay for coverage. And many other employers who have not been able to cover all of their employees or who have not provided coverage that is as rich as that envisioned in the President's plan will be paying more than they have in the past.

Because the small business community is extremely concerned about the potential burden this proposal may place on the economy, we believe that understanding how many employers are and are not providing health benefits for their employees is a vital component in the health care debate. While the White House has indicated that the "vast majority of employers currently provide health insurance for their employees", all the data we have seen paint a very different picture.

Based on data from the Health Insurance Association of America (HIAA), the Census Bureau, the Congressional Budget Office, the U.S. Small Business Association and others, we find that between 40 and 45 percent of employers provide health insurance. This percentage is driven by the huge number of employers with fewer than five employees (about 3,000,000 firms), of which only 26% provide coverage.

Percent of firms that do and do not offer health insurance (HIAA, 1989)

Firm size	Offer	Do not offer
Fewer than 5 employees	26	74
5–9 employees	54	46
10–24 employees	72	28
25–49 employees	90	10
50–99 employees	97	3
100 or more employees	99	1
Total	42[1]	58

[1] A 1992 HIAA study adjusted this figure to 40%.

Even the U.S. Small Business Administration's estimate on this matter states that 53.7% of employers provide health insurance for their employees. NFIB believes this figure is inflated because of the method used to extrapolate the data to the population as a whole. But even if you accept the SBA figure at face value, it still contradicts the White House claim.

The smaller the firm the less likely it is to provide health insurance. Not only do these firms pay higher administrative costs, but health insurance premiums represent a larger percent of their payroll because they tend to employ more marginal, lower wage workers. The lower the pay of the employee, the heavier the burden of health insurance premiums.

In general, we have found that cost is the primary determinant of small business owners' purchase of health insurance coverage. Health insurance is often the largest non-wage payroll item in a small rum, more than the cost of workers' compensation and liability insurance combined. Recent polls by Foster and Higgins showed a 79% increase in the cost of employee coverage over a four year period to $3,968. For many small firms, this figure can be considerably higher. Small businesses find the health insurance market extremely volatile and unpredictable, experiencing sudden cancellations and 20-300% annual premium increases. They pay 30-40% more in administrative costs than their larger counterparts, and struggle to find and retain their coverage. In order to keep their coverage, many have been forced to increase employee cost-sharing.

Employers of all sizes have been trying to find ways to control and slow rapid and unpredictable premium increases. Larger firms have been able to contain costs by self-insuring and moving into managed care arrangements. Smaller firms, however, have limited access to managed care options and are usually unable to self-insure. As a result, they are faced with expensive state mandates, state premium taxes, medical underwriting and higher administrative expenses.

EMPLOYER MANDATES AND JOB LOSS

The ever increasing burden of federal mandates on employers continues to raise the cost of starting or expanding a business and hiring employees. According to numerous studies, the result of these higher costs will be jobs lost or not created. A July 1993 survey of 2400 small businesses in seven cities, conducted by University of Michigan professor Catherine McLaughlin, indicated that one third would decrease their numbers of full time employees if they faced a health insurance mandate.

A 1000 member survey of the American Economics Association in June 1993 indicated that 80% of the economists interviewed projected a decrease in employment among all employees as the result of requiring employers to provide health benefits to low wage employees.

Another study, conducted by the Employment Policies Institute in September 1993, concluded that requiring employers to pay for worker's health insurance expenses would increase labor costs, leading to the loss of 3.1 million jobs. These job losses would be concentrated in just a few industries. 75% or more would be in restaurants (828,000 lost jobs), other retail trade (726,000 lost jobs) and agriculture (194,000 lost jobs). Other industries that will see disproportionate job loss are construction, repair services, personal services and private household services.

A CONSAD Research Corporation study conducted in May 1993 found that three leading health care reform plans requiring employer mandates could impact 7.5 million to 18 million jobs in terms of reduced wages, reduction of other benefits and potential cuts in hours worked. Job loss estimates ranged from 400,000 to over 1 million.

Even Administration officials acknowledge the potential loss of 200,000 to 700,000 low income jobs if some type of subsidy does not accompany mandated employer provided benefits, as was reported in The New York Times on August 30, 1993.

The White House attempts to address the job loss problem by including subsidies. However, the subsidies are temporary—the mandates are permanent. If the White House's predicted savings do not materialize, the subsidies may be doomed. They have already reportedly been reduced by $16 Billion since the Administration's plan was first revealed.

Small businesses do not want subsidies, they want affordable health insurance coverage. This was proved by a recent Gallup poll of small business owners that showed nearly half (46%) of business owners who opposed the mandate in the President's plan said the idea of a subsidy would strengthen their opposition to an employer requirement.

ADMINISTRATION HEALTH CARE REFORM PLAN

While we wait for the details of the President's health care reform plan to be submitted to the Congress, we can mention briefly some of NFIB's preliminary concerns about the package as we know it.

We believe the following are positive aspects of the plan:

Self employed individuals will be allowed to take a permanent 100% deduction for health insurance premiums, rather than the current 25% temporary deduction.

Insurance reforms are proposed in the President's package that would make insurance easier, and less expensive, to buy. These include guaranteed coverage for all regardless of health status, elimination of the pre-existing condition limitation, adjusted community rating and guaranteed portability of coverage.

Purchasing groups are created to enable small businesses and individuals to band together to purchase insurance more affordably. Members of the purchasing groups will receive detailed comparative information on health plans to help them make more effective choices for their money.

Paperwork and administrative simplification, including standard forms for claims, reimbursement, enrollment and plan visits, and electronic networks for data transmission and record keeping, will keep down costs and ease compliance.

Antitrust restrictions are loosened to make it easier for hospitals to jointly purchase medical equipment and allow doctors to share information and form networks of providers.

Medical liability reform, while it needs to be strengthened, will create an alternative dispute resolution mechanism for each health plan, limit attorneys' fees and include a collateral source rule (award reduced by amount recovered from other source).

Following is a list of parts of the plan we find troubling:

Employers are required to pay at least 80% of premiums for all employees and dependents, including part time and seasonal employees. Small businesses survive on cash, not profitability. While profitability is critical to long term survival, a profitable small firm can go out of business if it does not have enough cash to make payroll and pay bills. A mandate will critically impact the cash flow of small business, particularly start-ups or those firms that have not reached a mature enough level to have cash reserves.

The "subsidies" included for small firms are temporary; the mandates are permanent. The White House has stated that any changes in the savings expected from reform could doom the subsidies altogether or erode them over time.

Payment calculations are complicated and cumbersome. Employers must calculate payments based on four categories of "family status" (single individual, couple without children, single parent family, two parent family) and specific wage categories. If there is more than one worker in the family, employers must determine the per

employee cost by the following formula: 80% of family premium divided by the average number of workers per family for that region.

Recordkeeping and paperwork requirements involved in this proposal are far reaching. Employers must track the changing "family status" of each employee, furnish employees' names and other relevant information to the regional alliance, notify the alliance of new enrollees and forward new registration material within 30 days. At year end employer must reconcile total premium payments and report to the alliance. Complete records must be kept for alliance audits. Do the requirements of the Paperwork Reduction Act apply?

A standard benefit plan that is "consistent with a Fortune 500 plan" is not what most small firms offer, and may be too highly priced for many small employers.

While we are heartened that purchasing groups are included in the proposal, they appear to have turned into quasi-governmental monopolies with broad regulatory powers. Do the requirements of the Administrative Procedures Act and Regulatory Flexibility Act apply?

Approved health plans are allowed to contract exclusively with single source suppliers, which could mean many small independent service providers such as pharmacies will lose significant amounts of business to larger chains.

The national board envisioned by the President is charged with establishing and enforcing health care spending limits. How these spending limits are calculated by the board is unclear. In addition, the board appears to add a new layer of federal bureaucracy to the program, and gives inordinate power to the federal government to regulate the system.

States that are not in compliance with their budget may be able to levy an additional payroll tax on employers in order to meet the state budget.

States are allowed to opt out of the new system, and may choose a single payer system for all or part of the state. In addition, states are allowed to restrict the number of purchasing alliances in the state, thus reducing competition and increasing the possibility of quasi-governmental alliances.

States are allowed to add benefits to the standard package, although they must be separately funded. What is to keep a state, many of which have added state mandated benefits prodigiously in the past, from adding to the size and cost of the benefit package?

The President's proposal, while placing a heavy burden on small business, appears to be a boon for large corporations. Health obligations for early retirees (aged 55-65) will be transferred from corporations to American taxpayers, and overall health insurance costs could be significantly reduced for the big business community.

A SMALL BUSINESS HEALTH CARE REFORM PLAN

Small business owners believe that better alternatives to the President's plan exist. Many have already been introduced in the Congress and states like Florida have actually enacted some of them. Proposals that do not increase payroll costs on employers, particularly new businesses, would avoid the inevitable job loss associated with expensive mandates. Following is a list of guiding principles which we believe any comprehensive reform plan should follow. Taken together, we believe these measures will increase access to affordable health coverage and help to contain cost increases. While the list is not all-inclusive, it does represent the results of numerous surveys of small business owners over the last several years.

Formation of health insurance purchasing groups should be encouraged. By joining together to purchase health insurance, small businesses and individuals can reduce costs through administrative savings and risk-sharing. Referred to as "health alliances" by the Administration, these purchasing groups should operate under the following guidelines:

The alliance should act as a health insurance broker, negotiating annual agreements with insurers and approved health plans, enrolling members, collecting premiums and disseminating cost and quality information to help consumers make educated health care choices;

enrollment in the alliance should be completely open, with purchasers free to choose the plan that best suits them;

states should allow multiple purchasing groups in each area and operation across state lines;

the size of the purchasing group should be large enough to be effective, but not so large as to essentially create a "single-payer" entity within a state (i.e., membership in a single alliance should probably be restricted to firms with 100 employees or fewer, certainly not more than 500. We are currently collecting data to determine where the optimum number for small business lies); and

the alliance should be run by a local purchaser-controlled board.

Self-employed business owners should be allowed a permanent 100% tax deduction for health insurance premiums purchased for their employees and themselves. Self-employed business owners such as sole proprietors, partnerships and 5-corporations are allowed only a 25% deduction; that deduction is temporary. Expanding and making permanent the tax deductibility of premiums would enable many of the nearly five million uninsured self-employed to buy coverage for themselves and the millions they employ.

Insurance company practices should be reformed to make health insurance coverage easier and less expensive to buy. Being able to count on obtaining insurance with fairly stable premiums would enable more small business owners to purchase coverage for themselves and their employees. Specifically, any reforms in this arena should include:

elimination of the preexisting condition limitation;
guaranteed access to policies, regardless of medical condition, and guaranteed renewal of policies;
the elimination of experience rating and the institution of a fairer rating system such as rating bands or a system in which individuals are community rated, with considerations made for age and sex; and
portable insurance coverage for all, regardless of employment status.

Financing of the new system should be spread as equitably as possible, without overburdening our primary job creating sector—the small business community. Historically, small business has had a difficult time obtaining affordable health insurance coverage for its employees. For the millions of employers who find coverage prohibitively expensive, proposals that increase payroll taxes and force all businesses to cover all employees will be particularly devastating and should be rejected.

The small business community strongly opposes broad employer mandates to pay for health care reform. Recent surveys show that 88 percent of small business owners oppose a federal mandate requiring employers to purchase health insurance for all employees. Although very many small firms provide health insurance, most fear a broad government mandate for two reasons: the business owner's financial flexibility would be gone, and an expensive, politically-dictated benefits package could mean that their already high costs would escalate further. The bottom line is that mandated coverage may force many new and marginally-profitable businesses to lay off employees or shut down altogether. It would also significantly reduce the profitability of more established companies and inhibit their ability to expand and create jobs.

Similarly, those who wish to fund the new system by imposing a payroll-based premium are ignoring certain realities of the small business market place. Because small firms are so labor intensive, this.would in fact be the worst possible choice. Payroll taxes have no link to profitability and will only stifle new business start ups and inhibit job creation because they are a tax on jobs. Rather, reforming the system to make affordable coverage more widely available will encourage more small business owners to purchase coverage for their employees.

In addition, NFIB believes that the tax code should be amended to help control health costs and make purchasers of health coverage, whether employers or individuals, more cost-conscious in their choices:

the employer deduction for health insurance should be capped, with the savings used only to broaden access to basic standard health coverage;
the employee's current tax exclusion for health benefits should be capped;
the deduction/exclusion for both employers and employees should be tied to the average cost of the lower-priced health plans;
the deduction for the self-employed (currently 25%) should be permanently increased to 100% of the cost of the average plan; and
the above mentioned tax deduction should be tied to participation in a purchasing group, in order to encourage small business owners to join.

Costly state benefit mandates and anti-managed care laws should be preempted. Enactment of certain state laws have significantly limited the availability of affordable health plans and discouraged the growth of managed care systems. State mandates alone can raise the cost of insurance 30%. Pre-empting these mandates and repealing restrictive state anti-managed care laws would allow small business owners easier access to affordable plans and greater access to cost-saving managed care arrangements.

However, NFIB does not oppose state laws that require free and open competition for the business of managed care patients. NFIB members oppose exclusive contract arrangements with certain providers, such as pharmacies, within managed care sys-

tems. Small business owners believe that managed care systems can hold down costs effectively with open competition among many providers who are able to sell the same product at the same competitive price. Several states are currently considering laws that require managed care systems to allow all providers to compete.

A uniform, affordable standard benefits package should be developed in consultation with business and consumers. However, regardless of who determines what is in a "basic standard benefits package," care must be taken to ensure that the plan is at a level necessary to assure adequate coverage and care but remains affordable. As such, we should consider the packages developed by the most efficient and cost-effective health maintenance organizations. Developing Fortune 500 type "benchmark" packages that are too generous will price them out of the reach of individuals and small business owners. It is imperative that the package be affordable to both employers and individuals.

Accountable health plans (AHPs) should compete to provide high quality, low cost coverage to purchasers of health care. In order to be successful, it is crucial that there always be multiple, truly competitive AHPs. AHPs should operate as follows:

AHPs should be registered;
enrollment should be open in all AHPs;
plans must be subject to all reforms imposed on the insurance industry, including restrictions on the preexisting condition limitation, modified community rating, guaranteed availability, guaranteed renewability, portability, etc.;
AHPs must offer the uniform benchmark benefit package;
cost outcomes reports should be developed by all AHPs;
plans may charge different prices, but not based on health status;
plans should compete on the basis of price, quality and any additional services they can offer;
plans should not impose waiting periods or deny access to any enrollee, except in the case of capacity limits;
if higher premium plans are offered, the difference should not be covered (must be paid by individual or employer); and
consumers should be offered a choice among "actuarially equivalent" delivery options: HMO, PPO, or traditional fee for service. However, employers who are contributing to the cost of the premium should be allowed to encourage employee enrollment in a particular plan.

Attempts to control costs by imposing spending restraints or "global budgets" fail to address the root causes of the problem and should be avoided. Many have suggested the imposition of "global budgets"—caps on overall health care spending—in order to bring health expenditures under control. However, NFIB believes that global budgets are fundamentally unworkable (especially within a managed competition framework) and will lead to political rationing of health care. Currently, most experts agree that we do not possess the relevant data on which to base such allocations. Further, global budgets do not address the root causes of health care inflation, nor do they provide any incentives to increase efficiency in delivery of care.

Changing our medical malpractice laws. The current malpractice crisis only adds to the already astronomical cost of treatments, services, medical devices and pharmaceuticals, and inhibits research and development of new products. We believe that serious reform of the medical liability system can reduce the overuse of excessive and costly defensive medicine and save about $30 billion a year. Medical liability reform should consider the following:

limits on awards for noneconomic damages;
caps on attorneys' fees;
encouragement of alternative dispute resolution;
allowing use of treatment guidelines and protocols as a defense in malpractice cases; and
enterprise liability, which will create "deeper pockets" and encourage lawsuits, should be rejected.

Implementing administrative and paperwork reforms. As much as one quarter of every health care dollar in the U.S. goes to paperwork and administrative costs. Economies of scale for small firms mean that more of their health care dollar—up to twice as much as large businesses—goes to cover paperwork and administrative costs. As such, simplifying paperwork requirements and reducing administrative costs must be a part of any health care reform:

uniform claims forms should be developed; and
electronic claims filing, billing and enrollment should be more widely utilized.

If an independent board or national entity is set up to oversee the new health care system, it should be guided by the following principles:

its functions should be limited to establishing standards for information collection and data reporting, outcomes and consumer information, setting the general parameters of an affordable standard benefits package and general oversight;

such a board should not become simply another bureaucratic government entity that inhibits innovation and effective reform;

the board must include purchasers, be insulated from political pressures, and not be staff driven; and

the board's functions should not include setting global budgets.

Consumer information and education is essential. NFIB strongly believes that informed consumers make more cost-conscious decisions relating to their health care. Currently, part of the reason that health care costs are going up so rapidly is due to the fact that consumers have lost their sense of "shopping around" in the health care market. Most Americans are shielded from the true cost of their insurance coverage and the cost of medical care, largely because the premiums are borne by employers. As a result, there is little or no incentive to search out the highest quality health product at the lowest cost, a process fundamental in the purchasing of most other goods.

Miscellaneous.

In addition, NFIB strongly supports the following:

improved access in rural and underserved areas;

increased emphasis on preventative health;

removal of some antitrust restrictions on the medical community to allow providers to collaborate and pool resources;

increased cost-sharing among employers and employees to encourage cost-conscious decision making;

low income assistance to the poor and near poor;

CONCLUSION

As you can see from the list of principles above, there are numerous items on which we agree with the Administration and sponsors of other packages (encouragement of purchasing groups, insurance reform, malpractice reform, administrative reform, etc.). The controversial items, while critical, are few. We urge the Senate Labor Committee to seek passage of these consensus items as soon as possible.

We look forward to working with you to craft a reform measure that will control costs and encourage more small firms to purchase coverage for their employees. We hope to work with you to pass a reform measure in the 103rd Congress. Thank you.

The CHAIRMAN. Mr. Lindsay.

Mr. LINDSAY. Mr. Chairman, members of the committee, my name is Bill Lindsay. I am a principal with the Lindsay-Sandbak Group, a benefit management and consulting firm in Englewood, CO. We are, as Mr. Roush just described, a small business.

I am an active member of the health care policy committee of National Small Business United, which I am here representing today. We very much appreciate the opportunity to visit with you.

National Small Business United represents over 65,000 small businesses in all 50 States. Our association works to improve the economic climate to promote business growth and expansion, and we have always worked on a bipartisan and proactive basis.

For the last 4 years, health care has been our top Federal priority for concentration. Although we have many specific comments about the Clinton proposal, I would like to focus my testimony on the system of health care alliances that the plan would establish to deal with small businesses' purchase of health care coverage.

First, we need to consider the concept of a business mandate. We stringently oppose any form of business mandate, especially when it is paid for by higher payroll taxes. We oppose payroll taxes because of four primary reasons. First, they increase incentives to lower wages and reduce the number of employees. Second, they raise the hurdle for starting a new business or for hiring additional

employees. Third, payroll taxes must be paid whether a business is currently profitable or not. A highly profitable business will pay the same as one struggling to meet its payroll. And fourth, a mandate requires the development of subsidies for small and economically fragile businesses. Subsidies create a whole host of problems and complexities which result in significant administrative issues and, we feel, inherent unfairness in the system.

Now, in the interest of time, let me move on to the subject of health alliances. We are all familiar with the monopolistic health alliances being proposed by the administration. These alliances would have far-reaching responsibilities from enforcing budgets to delivering provider quality information to individual buyers. It seems unlikely that large and busy bureaucracies will find creative enough ways to encourage innovation and competition.

The key question is how to bring competitive forces to bear for cost containment when the individuals, who are paying only a limited amount for the cost of coverage, are allowed to make choices for their employers' dollars. In our view, small businesses should have the opportunity to form and run their own purchasing cooperatives. When you look at the economic landscape of other situations where alliances exist, such as in the agricultural community, they operate on that basis very successfully.

Many businesses which currently provide coverage and therefore might not otherwise oppose a mandate will most certainly oppose a provision which traps them into providing coverage from only one quasi-governmental source where they have limited or no options to select from.

Competing cooperatives will have strong incentives to negotiate tough deals from providers, which also will be extensively monitoring the quality of the care provided, maximizing the opportunity for cooperatives to establish themselves and compete for better deals in the marketplace.

The administration has been especially anxious about allowing multiple alliances, since they might seek to game the system, selecting only the best risks. We do not think that this is a realistic concern for the following reasons.

First, if all individuals must have coverage, such as under some form of mandate, we believe risk selection issues will be minimized. Second, in a reformed system, underwriting, the use of pre-existing condition limitations, etc, will go away, which again provides individuals free and open access to virtually any one of the health partnerships that they might wish to participate in. Third, risk adjusters could be added to address any differences in employee enrollment demographics, such as Medicare does currently for its risk contracting. Fourth, if businesses were making decisions about what cooperative to join, individual risk selection would not be a problem. Furthermore, by publicizing the other options that would be available in the community, the various markets would have an equal opportunity to participate in the plan that they selected. And finally and maybe most important, multiple alliances provide the employer with ways to avoid feeling penned in, a role that allows them to keep on shopping and look for ways to lower costs and increase efficiencies system-wide.

We appreciate the opportunity to testify. National Small Business United wants fundamental reform in the system. We believe that such reform is critical to the long-term survival and growth of business. But the new system must make sense, and it must fit the unique aspects of small businesses.

As you would guess, we have many other comments about the Clinton plan, and if there is further input or opportunity for input, we look forward to providing the committee with that information.

Thank you again for your interest.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Lindsay follows:]

PREPARED STATEMENT OF WILLIAM LINDSAY

Mr. Chairman: My name is Bill Lindsay, and I am a Principal with the Lindsay-Sandbak Group, a benefits management firm based in Englewood, Colorado. I am an active member of the Health Care Policy Committee of National Small Business United, which I am representing today. We very much appreciate the opportunity to be here.

National Small Business United (NSBU) represents over 65,000 small businesses in all fifty states. Our association works with elected and administrative officials in Washington to improve the economic climate for small business growth and expansion. We have always worked on a bipartisan and proactive basis. In addition to individual small business owners, the membership of our association includes local, state, and regional small business associations across the country. For the last four years, health care reform has been our top federal priority.

This hearing has been called primarily to ascertain our reactions to the health care reform plan of the Clinton Administration. Since the Clinton Administration has not yet released a detailed plan, we still have many specific questions about the practical operation of the plan. In terms of the costs and potential savings of the plan, those are also very difficult to address without having seen specific language or heard from CBO. Nevertheless, we will react as best we can to the outline that has been presented. Though we have many specific comments on the Clinton plan, I would like to focus my testimony today on 1) the impact of the mandate on small businesses, including the small business subsidy and payroll based premiums; and 2) the system of health care alliances that the plan would establish to deal with small business' purchase of health coverage, and the need for competitive purchasing cooperatives. But, before going on, I would like to give you a picture of where NSBU is coming from on health care reform, in order to put our response into perspective.

Our plan for ensuring that all employees of small businesses (and, indeed all Americans) have health coverage has been consistent for almost three years: 1) require everyone to have coverage; 2) reform the insurance system so no one can be denied coverage; and 3) institute a system of federal payments, based upon family income, so that everyone can afford coverage. It is a plan that responds to people, not to businesses; that responds to health care needs, not to employment status.

It is worth noting that NSBU agrees with the importance of all of the health care reform principles laid out by President Clinton during his presentation of the plan: security, simplicity, savings, choice, quality, and responsibility. We think that our own proposal encompasses all of these principles. In fact, we think that many items from our recommendations would actually heighten the President's plans adherence to these principles. Given our agreement on goals and principles, it is our hope to play a constructive role in the debate and to help design a system with which small businesses can live.

Of course, the details of our plan, like everyone's, become considerably more complex. We have to deal with critical issues such as who gets subsidized, how the plan gets enforced, what goes into a basic benefits package, how tight the insurance bands should be, and—the biggest question—how to keep a lid on costs; but all of these questions can only be addressed once we have decided the answer to the most fundamental question in this debate: Who pays?

I. THE MANDATE

The Choices

It seems to us that we have three distinct financing options for a universal coverage plan: 1) have the government cover everyone; 2) require employers to cover

all of their employees and dependents, with the government picking up the rest; or 3) require all individuals to have coverage, with the government subsidizing those who need it. We have rejected the government-run option on philosophical and substantive grounds. In addition, it is our perception that such a system stands little chance of adoption. Between the two remaining systems, we believe that the individually-based system makes far more sense—for businesses, for individuals, for providers, and for the nation.

Unfortunately, the Clinton Administration has chosen the employer-based approach—and along with it, an elaborate, cumbersome, unequitable, and painfully expensive system of subsidies for many small employers.

Problems With an Employer Mandate

Any employer-based mandate is essentially a payroll tax, but the Clinton plan makes that connection explicit by gearing premium levels to payroll levels for small employers. There are no more damaging taxes to small businesses and their employees than payroll taxes.

Of course, higher payroll taxes add to the cost of current employees, increasing incentives to lower wages and to reduce the numbers of employees. But probably of even greater importance is that these taxes would further raise the hurdle for starting a new business or for hiring an additional employee. The continuous flow of new business start-ups is one of the keys to the success of the U.S. economy. The total number of business start-ups must exceed the total number of failures in order to keep a growing small business community—and the gap between these groups is already closer than many people think. Unfortunately, payroll taxes are likely to increase the failures while making the start-ups more costly and difficult.

We should also remember that payroll taxes must be paid whether a business is currently profitable or not. A highly profitable business will pay the same as one struggling to meet payroll. And this, we feel, is perhaps the greatest problem posed by an employer mandate: its complete lack of flexibility. Under the Clinton plan, small businesses and their employees will no longer have the option of purchasing less expensive insurance in bad economic times, even if the business is quickly losing money. Unfortunately, the major remaining areas of flexibility for the business will be wages and the jobs themselves. This problem is one more reason that we believe that the health care mandate should be severed from the work-place.

The Small Business Subsidy

In an admirable attempt to deal with many of these employer mandate woes, the Clinton plan attempts to help small businesses through an elaborate and extraordinarily expensive system of subsidies. It sounds simple. Businesses with fewer than 50 full-time employees would have a cap on their health care costs of between 3.5 and 7.9 percent of payroll, depending upon its average size. In actual practice, this system could be extraordinarily complex. But there are many questions to which we do not know the answers.

First, how and when is business size computed? Many businesses have greatly fluctuating work-forces and may or may not fit under the 50-employee cap at any given point during the year. Recalculating the payroll cap with every pay period would obviously be very difficult. But using past experience (say, an average from the past year) could be very harmful to businesses in distress. For instance, a business that had 60 employees—and no subsidy—that has had to downsize to 35 employees because of economic hardship would receive no subsidy under a "look-back" procedure, even though it might need and deserve a substantial one.

More difficult still is the calculation about full-time versus part-time employees. Employers would be required to pay a pro rota share of premiums for part-time workers, based upon a 30-hour work-week. So, a business would pay 60 percent of the premium for an employee working 18 hours per week, and 33 percent for an employee working 10 hours per week. If an employee works 15 hours per week during one pay period and 25 hours per week the next, does the premium rate- change for the employer? Here, a look-back procedure could not really work since many part-time positions are new or temporary and there is no past experience on which to rely. We could go on with the potential practical problems of this type of subsidy for some time, but you get the idea of the kinds of problems we are describing.

An additional problem is the arbitrariness of the subsidy to businesses with fewer than 50 employees. If there are two competitors, one with 45 employees and one with 55 employees, there are probably very few differences between them—except that one could pay more than twice as much for health insurance than the other. There is every incentive for the second employer to get its number of full-time employees down to 50, whether through eliminating positions or simply reducing sev-

eral employees' weekly hours to below 30. We think this is the wrong basis for critical employment decisions.

So, how would we distribute subsidies differently? Unfortunately, we are only able to be critics of small business subsidies at this point. We can simply think of no way to equitably and effectively distribute health care subsidies to businesses. Do you subsidize the businesses that do not currently provide insurance? Tell that to their competitors who have been providing coverage and will receive no subsidy. Do you subsidize low-wage businesses—thereby encouraging low wages? Do you subsidize low-profit or low-revenue businesses? There are plenty of low-revenue businesses that are highly profitable, and there are plenty of ways to hide profits in order to collect federal dollars. Frankly, we are skeptical about whether there is a way to fairly subsidize businesses for health insurance, which is just one more reason we have rejected an employer mandate as the appropriate avenue for universal coverage. And it is one more reason that we support health care subsidies for individuals, based upon their ability to pay.

One of the primary reasons for considering an employer mandate has always been that significant employer financing relieves the federal government of the need to finance the care of many low-income individuals. Since an employer mandate avoids a lot of federal spending, it requires fewer new taxes and becomes more politically popular. Of course, we have a lot of trouble with a government that wants to avoid the tough choice of cutting spending or raising taxes—even for appropriate societal responsibilities—yet that insists on shifting those responsibilities to small businesses. But on a more practical level, we wonder whether the employer mandate in the Clinton plan saves the government any money at all. After all, the mandate is slated to cost almost $450 billion over five years in small business subsidies alone. In its zeal to make the mandate work, has the Administration forgotten one of the fundamental arguments for an employer mandate? We think that an individual mandate could be targeted to cost less than these government subsidies to small businesses, without all of the attendant equity and implementation problems.

Individual Mandate

As President Clinton has so consistently and correctly pointed out, small business is the engine that drives job creation and economic growth in this nation. Small businesses employ 57 percent of the private work force, make 54 percent of all sales, and contribute 50 percent of the gross domestic product. In the last decade, small businesses created the vast majority of new jobs. Yet, we also have to remember that small business jobs are more likely to be filled by younger workers, older workers, women, and part-time workers. Unfortunately, a health care mandate that drains tens of billions of dollars out of small businesses every year will put a dramatic damper on job creation and economic growth, affecting those workers and the businesses that employ them most of all.

Please understand where we are coming from: an individual approach is not an attempt by small business to duck responsibility for the health of their employees; over 80 percent of small business employees and their dependents have insurance. An individual mandate will not cause those businesses currently providing insurance to drop it. In fact, we think that requiring all individuals to participate in the system would actually increase the pressure that employees place on their employers to provide that coverage for them, causing employer-provided coverage to increase. Yet, there are situations where the added expense of health insurance would cause wage deflation, lost jobs, and even business closings. A system that responds to the needs of the employees and families of such businesses—on an individual basis—would be the best system. As important as it is to provide access to quality health care for all, we think that employment and jobs should receive equal attention, especially when there is a conflict between these two needs.

II. HEALTH ALLIANCES

Single Regional Alliances

Under the Clinton plan, all employees of businesses with fewer than 5,000 employees would be enrolled in their regional health alliance, to which their individual and employer premiums would flow. Once in the alliance, the individuals would choose from the various health plans that qualify to be offered by the alliance. At no point in the process are small employers, who will be paying most of the bill for their employees, given a choice or allowed any avenue to find a better value for their money—and they are certainly not given the chance to actually save money.

Under the Clinton plan, the health alliances will have far-reaching responsibilities—from enforcing budgets to delivering provider information to individual members. It seems unlikely that this large and busy bureaucracy will find creative ways

to encourage competition and innovation. There may need to be some sort of "health alliance" at the local level to coordinate provider expenditures and provide a framework for community-wide health care decisions. But these roles should be separated from the purchasing cooperative role, which is simply to bring businesses together to bargain for the best deal on coverage for their employees. Unfortunately, this dynamic cannot occur in the Clinton plan.

How are we to bring competitive forces to bear for cost containment when those who are paying are not allowed to make any choices for their dollars?

Competing Purchasing Cooperatives

Small businesses should have the right to organize and run their own health care purchasing cooperatives, in order to have choice and empowerment within the system. A mandate on employers which provides neither an avenue for these businesses to choose how to purchase coverage nor an ability to organize for their own best interests and survival will be very unpopular with small business. Many businesses which currently provide coverage, and might not oppose an employer mandate, will almost certainly oppose a provision which traps them into purchasing coverage from a single—potentially inefficient—source.

Moreover, we believe that private competing health alliances are essential for maximizing competitive forces for cost containment. Competing cooperatives will have strong incentives to negotiate tough deals with providers, in order to attract members. In areas where the market cannot sustain multiple cooperatives, they will not exist, thereby maintaining the efficiencies of larger pools. Multiple cooperatives represent an important component for maximizing the cost containment potential of managed competition.

The Administration has been appropriately nervous about allowing single, monopolistic (and monopsonistic, depending upon your point of view) health alliances to exclude health plans from participation in the alliance. The only mechanism the alliances would have to exclude plans would be a price cap and several other objective standards. But competing alliances could actually bargain with insurers and provider groups for the best deals for their members, and groups that would not deal could be excluded from the alliance. The competing alliances' ability to exclude insurers and provider groups would be one of their most powerful cost containment tools.

The Administration's plan allows large corporations with more than 5,000 lives to opt out of the health alliance system and self-insure. They will only do so if that action enables them to save money. Small businesses are given no similar opportunities to find cost savings in the system. Small businesses need this kind of flexibility even more than their larger counterparts. Moreover, even in a system of competing health care purchasing cooperatives, we believe that the ceiling for business participation should be much lower than 5,000 lives.

Risk Selection

Some opponents of competing health cooperatives have argued that competing health alliances will foster adverse selection problems, causing many of the plans to descend into a doomed "death spiral." We simply think that these arguments are somewhat overblown and should not be viewed as an insurmountable problem. If all individuals must have coverage, and all providers and alliances must offer coverage and accept individuals under the same conditions, we believe that the risk selection problems will be relatively minor.

But, if necessary, there are several ways to deal with potential risk selection problems in a competitive purchasing cooperative environment. Since adverse selection has primarily to do with individuals "gaming" the system for their own benefit (sick people enrolling in the most expansive plans and young healthy individuals choosing HMOs), we expect most risk selection problems to occur within the purchasing cooperatives, rather than between them. Within the purchasing cooperatives a risk adjuster could be used, just as the Administration plans to use in their health alliances' health plans, which will have the same problems. Such a risk-adjuster would essentially allow insurers to insure against having too many unhealthy individuals in a plan. This mechanism will spread the costs of caring for the sick equitably across all carrier groups.

In a system of competing health purchasing cooperatives, businesses would be making the decisions about which cooperative to join, so the individual risk selection problem would not exist. Any risk selection would occur from the relatively subtle marketing decisions of the purchasing cooperatives. For instance, purchasing cooperatives could choose to only market their services to "better risk" businesses in better risk areas—assuming these non-profit entities were wily enough to have that knowledge. But it would be relatively simple to circumvent this problem by inform-

ing all businesses of all purchasing cooperatives which are available, along with a thorough description. And if cooperatives attempt to serve one part of a region differently than another, it would be easy enough for the states to draw boundaries in a way to make this practice at least very difficult.

Again, competing purchasing cooperatives are likely to provide greater cost containment than single alliances; competing cooperatives can be structured to avoid risk selection problems at least as well as single health alliances; competing cooperatives provide small businesses with empowerment in the system, room to maneuver without feeling "locked-in", and a role in keeping costs down system-wide. We think that the issue of competing purchasing cooperatives will ultimately be one of the key small business issues in this debate, unless it is addressed early-on.

III. CONCLUSION

We appreciate being invited to testify today. National Small Business United wants fundamental reform of the health care system; we believe that such reform is critical to the long-term survival and growth of small businesses. But the new system must make economic sense, and it must take the unique problems and limits of small businesses into account. As you might guess, we have many other comments on many other aspects of the Clinton plan. If there is any further input that we might be able to provide to the Committee, we will be pleased to do so. Thank you.

The CHAIRMAN. Ms. Mills.

Ms. MILLS. Good afternoon, Senators.

My name is Helen Mills. I speak to you today from several perspectives—first, as a founding board member of Businesses for Social Responsibility; a founder and managing principal of The Mills Group, an employee benefits brokerage and consulting firm; also, I own another small business which is a franchise of The Body Shop, a five-store retailing operation in Washington, DC; and perhaps most importantly as a concerned citizen.

I would like to begin my testimony by observing how vitally important it is to our Nation's economic health that our populace become informed about and actively debate the options for reforming the health care system.

President and Mrs. Clinton have shown tremendous courage by throwing down the gauntlet to begin the dialogue at a national level. And you, Senator Kennedy, the long-term and consistent leadership you have demonstrated in the health care arena has been instrumental in bringing us to this point.

Foremost in this effort is the importance of providing universal coverage for all. This is the most urgent and most noble goal of the President's proposal.

I have been in the insurance business since I was 15 years old. Over the years, I have sold term policies to single mothers and disability plans to sole proprietors, provided incentive plans for executives, and implemented group plans for companies with over 10,000 employees. And under our health care system as it stands today, I have begun to feel like a doctor treating a terminally ill patient.

Let me give you an example of the type of situations I deal with. I received a call from a family friend whose 24-year-old son was dying of cancer. He was in the hospital and had been fighting a brilliant battle for 2 years. That day, the father had received two calls. One was from the son's employer, and one was from the employer's insurance company.

The son's employer was calling to lament that the insurance company had called to say that as long as this boy was on the plan, his rates were going to go up 400 percent, and that meant the demise of his company.

Later, the insurance company called the father to say that $1 million worth of treatment was going to be unpaid because they had categorized it as experimental.

This story typifies the inequities and unfairness which ripple through our system, dividing our society into the haves and the have-nots, as underwriters cherry-pick or skim the cream off the market and overcharge for the privilege of doing so.

My Mills Group clients and the businesses I have spoken to that belong to Businesses for Social Responsibility feel the system is unjust and must be immediately and dramatically reformed. The health care issue transcends whether you identify with a donkey, an elephant, or a diminutive Texan, for that matter. It is wholly an American issue.

The Clintons and their team of advisors have drafted a thoughtful, meaningful and comprehensive plan, and while my colleagues and other business leaders have varying sentiments about some of the particulars of the proposed plan, most agree with the cornerstones serving as the foundation of the plan. I would like to talk about those briefly.

First, the mandates. Requiring all employers to provide health care levels the playing field between those of us who have been providing coverage and those who have not. It removes the potential for unfair competitive advantage in the marketplace.

The decision of a business owner to provide health care for his employees should not create a competitive disadvantage. While philosophically, I am no fan of Government mandates, in this package, it means that I as a small business owner am no longer paying an extra load in my premiums for all the charges incurred in the system by my uninsured competitors. This is a matter of fairness.

Second, purchasing power. It is a reality that small businesses are hostage to their carrier's inequitable, discriminatory rules and untenable rate increase. If an employee has been to a marriage counselor, suffered back pain, or experienced almost any other illness, a new carrier frequently will not accept the group. I have had to finagle my own way with both of my businesses to covering my employees by finding loopholes in the systems to link with larger companies to provide coverage.

It is a fact that small companies cannot negotiate their rates like large companies can. I recently chatted with a friend of mine who is the owner of a Fortune 100 company, and he was describing his insurance renewal process. He was talking about his ability to negotiate lower rates for his company, but he acknowledged the cost of those savings would be passed on to small business. We as small business owners and individuals do not have the luxury of negotiating, of saying, "Take 15 percent off, and you have a deal."

The concept of alliances that pool small companies will help spread the risk and share the burden while reducing the administrative charges that small companies presently disproportionately bear. No one in business wants more Government bureaucracy. But in this case the alliance system, or some form of that, should reduce total administrative costs. I cannot imagine a system more bureaucratic than the one we have now.

As an advocate for a free market economy I find myself, as others do, succumbing to the realization that free market forces have sim-

ply failed to effectively control health care costs. Increases in costs outpaced corporate profits last year by 108 percent. The alliances should foster a cost-effective and competitive environment with regulatory power to assure that all the stakeholders in the system are fairly balanced.

The third cornerstone is the subsidies for business and the caps. As the plan appears now, many small businesses who want to cover their employees but cannot afford to do so under the current insurance system should find relief in the concept of subsidizing benefits under the new plan.

The plan will actually allow me a wonderful opportunity. Currently, I cover all of my 14 full-time employees in my Body Shop retail business. Under the proposed maximum schedule of the new plan, I will be able to cover my 35 part-time employees as well for only $150 more per month than I am paying now.

The proposed 7.9 percent cap should help protect employers and balance the current inequities in the system. The majority of my Mills Group clients and many of the companies I have spoken with at Business for Social Responsibility are paying between 6 and 10 percent of payroll in health care costs now.

Fourth is the budget. All good businesses run on a sound budget. The President's proposal establishes a budget that is tied to the consumer price index. This feature, coupled with other caps and cost controls, should give business owners and individuals alike the comfort of knowing there is top-side protection where absolutely nothing exists like that now.

Senators, it will be easy to find problems with this plan—or any other plan, for that matter. Achieving consensus will be a challenge unlike any you may face during your tenure as a public servant.

I urge you not to square off into your traditional corners. I urge you to rise above the political face-off and find the way—find the way to put people before politics; find the way to implement a reform package which manages costs while providing coverage for all our fellow citizens.

Thank you very much.

[The prepared statement of Ms. Mills follows:]

PREPARED STATEMENT OF HELEN H. MILLS

Good morning, Senators. My name is Helen Mills. I speak to you today as a Founding Board Member of Business for Social Responsibility; as the Founder and Managing Principal of The Mills Group, an employee benefits brokerage and consulting firm; as a small business owner who serves as President of the Soapbox Trading Company, a five-store retailing franchise of The Body Shop; and as a concerned citizen.

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Foremost in this effort is the importance of providing universal coverage for all. This is the most urgent and noble goal of the President's proposal.

I have been in the insurance business since I was fifteen years old. Over the years, I have sold term policies to single mothers and disability plans to sole proprietors, provided incentive plans for executives and implemented group plans for companies with over 10,000 employees. And, under our present health care system, I have begun to feel like a doctor treating a terminally ill patient.

Inequities and unfairness ripple through our system, dividing our society into the "haves" and the "have nots".

My Mills Group clients and the businesses that I have spoken to that belong to Business for Social Responsibility (which doesn't take stands on public policy) feel the system is unjust and must be immediately and dramatically reformed. The Health Care issue transcends whether you identify with a donkey, an elephant, or a diminutive Texan, that matter. It is wholly a America issue.

The Clintons and their team of advisors have deed a thoughtful, meaningful and comprehensive plan. And, while my colleagues and other business leaders have varying sentiments about some of the particulars of the proposed plan, most agree with the cornerstones serving as the foundation of the plan. I would like to discuss those now.

First, the mandates. Requiring all employers to provide health care levels the playing field between those of us who have been providing coverage and the minority of business owners who have not. It removes the potential for unfair competitive advantage in the marketplace.

The decision of a business owner to provide Health Care for their employees should not create a competitive disadvantage. While philosophically I am no fan of government mandates, in this package it means that I, as a small business owner, am no longer paying an extra load in my premiums for all the charges incurred in the system by my uninsured competitors. This is a matter of fairness.Second, purchasing power. It is a reality that small businesses are hostage to their carrier's unequitable, discriminatory rules ad untenable rate increases. If a employee has been to a marriage counselor, suffered back pains or almost any other illness, a new carrier frequently will not accept the group. I have lived through this on many occasions with my clients and my own business. Further, whole industries are excluded by many carriers.

It is a fact that small companies cannot negotiate their rates like large companies can. The owner of a well-known Fortune 100 company told me recently about his annual insurance renewal process. He was able to negotiate lower costs for his company, but acknowledged the cost of his savings will be passed on to small business. We don't have the luxury of negotiating, of saying "Take 15% off and you have a deal".

The concept of Alliances that pool small companies will help spread the risk and share the burden while reducing the administrative charges that small companies presently disproportionately bear.

No one in business wants more government bureaucracy. But in this case the Alliance system should reduce total administrative costs. I can't imagine a system more bureaucratic than the one we now have—one in which, in some cases, requires small businesses to spend up to 40% of their premium dollar for administrative costs.

As a advocate for a free market economy, I find myself, as others do, succumbing to the realization that free market forces have failed to effectively control health care costs. Increases in costs outpaced corporate profits last year by 108%. The Alliances should foster a cost effective and competitive environment with regulatory power to assure that the stakeholders in the system are fairly balanced.

The third cornerstone is the subsidies for business and the caps. As the plan appears now, many small businesses who want to cover their employees, but cannot afford to do so under the current insurance system, should find relief in the concept of subsidizing benefits under the new plan.

This plan will allow me a wonderful opportunity. Currently I only cover 14 full-time employees in my Body Shop retail business. Under the proposed maximum schedule of the new plan, I'll be able to cover my 35 part-time employees as well for only $150 more per month.

The proposed 7.9% cap should help protect employers and balance the current inequities in the system. The majority of my Mills Group clients and many of the companies I have spoken with at Business for Social Responsibility are paying between 6 ad 10% of payroll in health care costs. As a rule, those with high claims are paying more ad those who have strong managed care plans or those who are shifting a greater portion of the price to the employees are paying a lower percentage of payroll.

Fourth, is the budget. All good businesses run on a sound budget. The President's proposal establishes a budget that is tied to the consume-price index. This feature, coupled with the other caps and cost controls, should give business owners and individuals alike, the comfort of knowing there is top-side protection where absolutely nothing exists like that now.

Senators, it will be easy to find problems with this plan—or any other plan for that matter. Achieving consensus will be a challenge unlike any you may face during your tenure as a public servant.

I urge you not to square off into your traditional corners. I urge you to rise above the political face-if and find the way—find the way to put people before politics—to implement a reform package which manages costs while providing coverage for all our fellow citizens.

The CHAIRMAN. Thank you very much.

Since it is just Senator Coats and myself, we'll try 10-minute rounds for questioning.

I have here the October 15, 1993 statement of the Chamber, and in the report, for September-October, they talk about a poll that the Chamber did with regard to the mandate issue. It says—and this is talking about the businesses—"To elicit their views on the desirability of mandate that employers contribute to the cost of health insurance, the interview said: ' Some employers are concerned about proposed legislation on a mandate on all employers to provide or contribute to the cost of health benefits for their employees. Others contend that a mandate is the only fair way to see that everyone has health insurance, and that when employer A does not provide coverage, other employers indirectly pay for coverage of employer A's workers. How do you feel about requiring all employers to contribute to the coverage of their employee?' Small business owners were then asked to indicate whether they strongly support mandate contributions, somewhat support, or are neutral, somewhat opposed, or strongly opposed. Our survey found that close to half, 42 percent, of all small businesses, support the principle that employers should be required to contribute to the cost of health insurance for their employees. Even among firms not currently offering insurance, close to a third say that they support such a requirement among firms now providing coverage. Fifty-one percent favored mandated contributions."

Then it continues: "This level of support for a mandate is much higher than earlier surveys of small business have found. For example, in an 1989 survey, members of the NFIB found only 25 percent agreed that employers have a responsibility to provide employee health insurance."

Then it goes on to other paragraphs. "On the issue of imposing overall budget limits for health care spending, respondents were similarly asked to indicate whether they strongly support such measures, somewhat support them, or are neutral, somewhat opposed, or strongly opposed. Many small business owners, 66 percent, indicated they would like to see overall limits or budgets for health care spending imposed as part of a health care reform strategy." And it goes on into other areas as well.

On the issue of the mandate, I always wish we could find another word that could be used. I am always looking around for the person who labelled the MX missile "the Peacekeeper." I thought that was just a magnificent terminology, and I would like to find that person. If we could find another word instead of "mandate," I think we would all be better off.

I would ask the panel, is this basically a moral position in opposition, or is there an economic rationale as well? We have two members of this panel who favor a mandate. As I understand, Mr. Lindsay favors an individual mandate.

Mr. LINDSAY. Yes.

The CHAIRMAN. So we have that kind of development. I am interested in whether there is a moral, economic, or some other rationale at issue here.

Mr. PATRICELLI. Senator, if I may start on this, first I would like to make a slight correction in that the survey you were quoting was not a Chamber survey. It was done by a private group and published in the Journal of American Health Policy. But we thought it was very interesting, and indeed we believe it understates the potential for support for a mandated approach among small business because, as you noted, it involves nothing by way of subsidy. And the Chamber support for a mandate is very crucially conditioned on the presence of some Government subsidy to help low wage workers and their employers.

So we believe, given the opportunity to comment on that kind of a support mechanism, even more small businesses would support it.

The CHAIRMAN. So this did not include the subsidy?

Mr. PATRICELLI. No; no reference to subsidy.

The CHAIRMAN. OK.

Mr. PATRICELLI. Now, your point is a good one. Is this a moral issue? As you can imagine, we struggled within the Chamber on this issue, and we finally came to conclude that indeed it was not a philosophical, ideological issue. Business faces numerous mandates now. In fact, it seems to be forgotten that all businesses now have a health care payment mandate. It is called Medicare. And even small businesses are paying about 1.5 percent of payroll for health care, ironically, mostly for people they have never seen.

So mandates exist, and ideologies should be behind us. The issue that we confronted was who pays. And on that issue, our view is that what we need is shared responsibility. We encourage the substitution of that term for mandate. We believe everybody has to be required to participate, and that is employers, individuals, and Government.

The CHAIRMAN. Mr. Roush.

Mr. ROUSH. Senator Kennedy, as I indicated, we try to determine our positions by polling our members, and sometimes in doing that, we are not always able to determine the reasons for which they give the responses that they do give.

In this particular case, however, we have been involved in this issue for so long, and we have polled it so many times, in so many different ways—we have had outside people poll it, Gallup poll it and use their own standards for posing questions and variations—that it comes down to primarily a cost question. But there is a very large core of small business people, our members particularly, that seem to view it as, yes, an ethical if not moral question, in the sense that they ask: How did it all of a sudden get to be my responsibility to pay for the health insurance of my employees? Am I thereby responsible for paying their mortgage? Am I thereby responsible for paying their car payments?

So, yes, there is a core—and a substantial core, I believe, from the checking we have done—that views it as an ethical question and a question of personal responsibility.

Now, having said that, at the same time we ask other questions of them, and 69 percent of our members agree that every American

has the right to basic health care; 63.5 percent believe that every American should receive a minimum level of health care regardless of their ability to pay.

So we are left in the position of trying to interpret what those kinds of results mean, and in this case, cost and, underneath that, ethical.

The CHAIRMAN. That is not entirely surprising. I was looking at some studies on crime where 70 percent of the American people want tougher sentences, but only 30 percent of them now favor building more prisons. So I think we get caught in these kinds of inconsistencies in many different areas of public policy.

Mr. Lindsay.

Mr. LINDSAY. Thank you, Senator.

You asked if this is a conceptual issue, or is it a financial or cost issue. I really think that for most small businesses, it is both.

First of all, I agree with the statistics from NFIB about the nature of small business owners. Most small business owners are in business for themselves because they are rabidly independent. That means that from a conceptual standpoint, they resist any intrusion of the Government into any other aspect of their lives. So there is a very strong conceptual aspect to that.

The first speaker referred to the example with Medicare, that that is a mandate we all pay. But I would remind him and remind the Senators that that cap with Medicare first was limited to the normal wage base; just a few years ago, that wage base was raised to a level of $150,000, and just last year it was taken off. So that is an unlimited tax at this point. It is that lesson that is instructive for business owners. They say, "Well, I may only have to pay 3.5 percent now, but what is it going to be next year?"

The second point that I think the first and second panels spoke to, which may have been inherently inaccurate, when we talk about this cost shift from one business that does not provide health care to another business that does, although that is true, we need to remind ourselves that by far the greatest aspect of cost shifting does not occur from the uninsured to the insured, but rather from the Federal and State Governments who do not pay their full share. So there is a much broader issue here than just simply institutionalizing the cost shift by developing a mandate so that we level the playing field.

The CHAIRMAN. Ms. Mills.

Ms. MILLS. It is both. Often, business is put in the position that what is good economically may not be good morally. I think the moral issues override here, and I speak personally in that regard, that it is unconscionable that we have 37 million uninsured. I think it is something that needs to be addressed, and if it is mandates that have to do it, to bring people to the plate and pay their fair share, then we have to do that. But I do feel subsidies are a part of the solution, a critical part.

The CHAIRMAN. Mr. Roush, you have indicated that about half of all of your members, the smaller businesses, do provide some health insurance.

Mr. ROUSH. I indicated in my oral statement about half of all businesses. Actually in the category of those having one to five employees, it is 26 percent.

The CHAIRMAN. And below 25 employees, I think it is about 43 or 44 percent, I believe.

Mr. ROUSH. I believe it is in that neighborhood, yes.

The CHAIRMAN. Yes, those are general figures. Small businesses that have a small number of employees, their premiums have been escalating dramatically in the period of the last 3 or 4 years. You can tell us what they have been average nationwide.

Mr. ROUSH. Per employee now, it is something like $3,900; just a few years ago it was down under $3,000. So they are getting hit very hard; you are exactly right.

The CHAIRMAN. So how do you view this program with regard to those small businesses that are today providing health insurance?

Mr. ROUSH. The program that the President is going to be putting forward?

The CHAIRMAN. Yes.

Mr. ROUSH. Senator, I do not mean to be cute by this answer, but there is no legislative language yet, so I hesitate to criticize or comment in too great detail because the legislative process is such that you need to have the language to know what the program is.

But having said that, in general and conceptually, as I indicated in my opening statement, we support the concept of purchasing cooperatives; we support the concept of insurance reform. And to the extent that those are in the President's package, we are certainly willing and interested, as I think lots of people have indicated, in working out the details of those things and support them conceptually.

We have problems, as others have indicated, with some of the ways they are going, but none of those things are deal-breakers from where we are sitting.

The one thing that is of major concern that is in the President's package is the employer mandate, and we believe that the goals that the President set forward, the six guiding principles that he established, can be achieved without that component, and I think that people are trying to reach that point—Congressman Cooper, Senator Breaux, perhaps soon, Senator Chafee. I think people are trying to reach that point without the trading of health security for job security.

The CHAIRMAN. OK. We will either have you back to respond in more detail, or get further reaction from you for the record.

Senator Coats.

Senator COATS. Thank you, Senator Chairman. You actually tracked right down the line of questioning I was going to pursue, which made me a little nervous that you and I were thinking along the same lines. In fact, I asked my staff if I was given your questions. [Laughter.]

They are very valid questions, and I think everyone here has basically said that for this thing to work correctly, we have got to get universal coverage. And yet how do you get that coverage for those who currently are not covered or who are undercovered, without imposing some kind of mandate. It is a dilemma that we are trying to deal with there.

Let me just ask a side question. Has either the Chamber or NFIB done any models relative to job impact? I am particularly interested in job impact as it affects small business.

Mr. ROUSH. Senator, yes. We are searching, and we believe we have found a research firm that is capable of doing that, and as soon as we have the details, we intend to submit them to the firm with that explicit purpose of trying to find the job loss effects of the proposal.

So we have not done it yet because we do not have the details, but when we do, we will.

Mr. PATRICELLI. Nor have we, Senator Coats, the problem being that all of the studies to date deal with possible job impacts independent of any of these subsidy devices. We are unaware of any studies that look at the cushioning of the subsidies on a possible job loss.

So like the NFIB, when we have a good sense of that subsidy formula, we too will go out and get some research.

Senator COATS. Some of the larger companies, particularly those in the retail and service business and those that tend to employ lower wage earners or part-time workers, have come forward—K-Mart and Federated Department Stores and so on—with job estimates. Are they based on models or studies, or just estimates? Have you had a chance to analyze those? Or are they in the same position, essentially, waiting to get the final details, before you can get hard, firm numbers?

Mr. PATRICELLI. We have not been inside their estimates, nor do we know whether they include some specific reference to possible subsidy supports for their firms.

Mr. ROUSH. And I do not know, either.

Senator COATS. Well, those will be helpful when we get the details.

Do any of you have any suggestions—we talk about no pre-existing conditions, deductions for small business owners at the rate of large business owners, portability, etc. But those are all changes that impact on the costs of administering the system.

If you do not go the mandate route, do any of you have any suggestions as to how we can bring in the uninsured or the low-income underinsured, without mandating? I mean, should we look at Government-sponsored community health centers across the country to provide a basic level of benefits? Should we look at the availability of a tiered benefits package at a lower cost? I know no one wants to go to a tiered system, but do you have any thoughts about optional ways of providing at least basic coverage without mandating employer coverage?

Mr. LINDSAY. Senator, just as a comment, our firm worked for quite a few years as a consultant to the Robert Wood Johnson projects of the working uninsured across America. I am sure that both the Senators are familiar with those studies. Those studies were very interesting. They polled small businesses, primarily those with less than five employees—because that is where the working uninsured are by number—as to the primary reason for them not offering insurance. The primary reason was cost. The second reason, which was closely behind the first, was fear of future cost increases. And then the number of responses fell off dramatically from that.

So what that tells me is that there are two ways to approach this problem. One is an accessibility problem, which you can do effi-

ciently through the Government by just making it law; you mandate it. But the other one is really addressing the issue of cost.

Now, the Clinton proposal, as best we all know, has many provisions in there to try to address some of the drivers in the cost system. But we have a real strong belief that if there are aggressive and effective cost containment strategies that are put in place throughout this country, that alone will help many small businesses be able to afford coverage without a mandate and make them feel comfortable and safe in offering a plan of benefits that will not only be available today, but will be affordable in the future.

Senator COATS. Would you suggest, then, that the cost savings aspects of the plan be implemented first to demonstrate the viability of that and then see how business responds, and if they do not respond, then——

Mr. LINDSAY. That is certainly a viable option that is being discussed in many circles—rather than fight the battle of the mandate, to ask can we do something to make the coverage more affordable.

The sense that I have just anecdotally with my peers is that most small businesses really would like to be able to provide coverage for their employees. The two reasons that they do not are that, one, they cannot afford it, and/or they have pre-existing medical conditions.

The interesting development is that since the Clinton proposal has emerged, it has had a significant effect on health care reform in America. Health care reform is going on right now in many States through the National Association of Insurance Commissioners passing laws that outlaw pre-existing conditions, that outlaw medical underwriting. The problem with those laws is that they generally do not curtail costs.

So to answer your question, I would say that if there were effective cost containment, it would be interesting to see first what that would do in the system and whether or not we would bring enough people into the system to be able to avoid having to have a mandate.

Ms. MILLS. We have had HMOs who, in the beginning, did not have pre-existing condition clauses, and their rates have been growing at half the rate of a pure indemnity plan, and still businesses did not choose to do that when there were no pre-existing condition rules. Now there are pre-existing conditions rules in HMOs. The costs are still lower, but there was the opportunity there, and many businesses did not avail themselves of it.

Mr. PATRICELLI. Senator, it was the Chamber position for many years that we could virtually close the coverage gap through voluntary efforts that would lower the cost of coverage to small business through a combination of cost containment and perhaps some kind of tax credits or something like that.

However, like Mr. Lindsay, we followed closely the results of that Robert Wood Johnson program in which I believe seven or eight communities tested the effect of special subsidies on small businesses choosing to implement insurance programs, and to us the very disappointing conclusion of that set of studies was that lowering the cost, subsidy alone, did not produce significant sign-ups of

new business, with the single exception of the State of Florida, for some reason.

Now, perhaps that had to do with context and extraneous factors, but we were reluctantly led to the conclusion that absent some kind of national framework of requirements for business, individuals, and Government, you are not going to get there.

Mr. LINDSAY. Senator, if I could just respond to that, I think that is an interesting point, but again, because I was involved in those programs, the point that I would raise with the statement by the Chamber is that in follow-up interviews with many of the businesses that did not elect to participate in those subsidy programs, the main reason they did not was that these were experiments, and they did not believe that the subsidies would continue. Their concern, therefore, was what happens if I sign up today and look like a hero to my employees, and 2 years from now the State can no longer afford the subsidy; then I am going to look like the bad person by taking it away. That specifically happened in several States when the legislature, as coverage started to increase and people started to be covered, became very concerned about the additional cost and had to look at cutting back on those approaches.

So my commentary on addressing cost is not with artificial subsidies that artificially reduce the rates and cannot be sustained over time. I am talking about systemic change in our health care system that would have long-term and lasting cost effects.

Mr. ROUSH. Just very briefly, we believe that the changes to bring costs down will in fact increase coverage, but we are not convinced, based on our own surveying, that it will accomplish universal coverage in and of itself. Our surveys indicate that about 10 to 15 percent of small business people say that under no circumstances would they ever provide health insurance.

The vast majority, however, who do not now have health insurance for their employees want to do it, and in the surveys, just as Mr. Lindsay indicated, cost is why they are not.

So you will get a dramatic increase in coverage by the kinds of voluntary programs you are talking about, but you will not get everybody, I do not believe. I believe Senator Chafee's proposal has ways of getting at those through vouchers; and Congressman Cooper tries to get at them through individual tax kinds of things.

One other point if I could, just briefly. There is a sense that—and the President has said this numerous times—we already have universal coverage. The question is rationing it so it is paid for more reasonably.

Those are some comments.

The CHAIRMAN. Let me ask Mr. Lindsay, do you really think that by encouraging the coops and the other suggestions you have made that you can really get a handle on the issues of cost in the total system? I mean, won't we just have continued cost shifting?

Mr. LINDSAY. I think that to a certain degree, Senator, you are always going to have some degree of cost shifting. I would suggest that even in the administration's proposal with Medicare being a significant payer in the system, outside the system you will still have cost shifting from Medicare to everyone else.

So I think to some degree you will always have cost shifting. But I think the real reason why you have cost shifting, again, is be-

cause of the nature of the costs in general. There are a lot of aspects of the administration's proposal that would get at costs. There are other things in addition that maybe are not included at the present time that could be added that would further address the issue of cost. And I guess, speaking on behalf of National Small Business United, we would rather see the focus on the cost rather than the mandate initially, and then work through it on that basis.

The CHAIRMAN. We saw earlier in the year an enormous amount of political pressure to put limitations on the Medicare and Medicaid programs, and that only missed by 8 or 10 votes. And if this process does not move ahead, that thing is going to whistle through here, and who will end up paying for it? Chamber members, who currently have some coverage. It is going to be that 40-odd percent of small businesses that will see their premiums go up, and it will just break the backs of many of those small businesses as well. It has a head of steam, and the political reality is that people want to cut Government spending, and that is coming down the track as well, with all the implications it has in terms of shifting costs to the private sector.

That is why it is enormously important to understand that we are all in this together, whether we like it or not, and to try to think anew about some of these issues; that's really what is required. It was mentioned earlier in the course of the hearing, and that is certainly something that we are all going to try to come to grips with.

This has been enormously interesting. On these health care issues, I say I always learn a great deal, and I have a lot more to learn, from the hearings.

I am grateful for the very constructive attitude that has been taken by the small business community and the business community generally. There are differences, and we should not minimize those differences, but there is a great deal of common interest and an even broader common understanding and awareness about where we are at this time in this debate. I daresay, as someone who has been involved in the issue over some period of time, that 5 years ago, we would never have had this kind of a panel with the level of discussion and interchange that we have heard here today. We have all come a long way, and I want you to know that we are interested in trying to find additional common ground. There will probably be areas where we just cannot, but I think certainly the attitude of the President and having been with Mrs. Clinton earlier this morning, there is a very deep desire to maximize the areas of common interest and see how far down the road we can go, because as was mentioned by Ms. Mills, and I believe very sincerely, this is in many respects the issue of this generation. It is what Social Security was in the 1930's and Medicare was in the 1960's. And the institutions are really on trial. There is a lot of questioning about institutions around here. But the American people are really wondering whether Republicans and Democrats can work together, and whether the different elements in terms of our private sector can work with the institutions, and whether we can come to grips with an issue as complex and difficult as this—an issue that has the most dramatic impact on every family in this country.

That is really going to be the challenge of the time, but I am very much encouraged by the positive attitudes of our witnesses today. We look forward to working with you.

Senator Coats has left, but we are having hearings next week on the whole question of the macroeconomic impact of the health care reform issue. We have had some hearings in the past which I think dealt with the issue in an important way, but we will be looking at that issue as well as the issue of retirees.

Thank you very much. The committee stands in recess.

[Whereupon, at 12:50 p.m., the committee was adjourned.]

ECONOMIC IMPACT OF THE HEALTH SECURITY ACT OF 1993

TUESDAY, OCTOBER 19, 1993

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10:02 a.m., in room SD–430, Dirksen Senate Office Building, Senator Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Harkin, Wellstone, Wofford, Kassebaum, Jeffords, Coats, Gregg, Thurmond, and Durenberger.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. The committee will come to order.

We welcome this morning Dr. Laura Tyson, who is the chair of the President's Council of Economic Advisers, as our first witness, and a very distinguished group of health economists in our second panel.

This committee is attempting to focus on a variety of different aspects of the health care crisis, and today we want to give consideration to some of the macroeconomic implications of the President's program. And there is no one who is better qualified to be able to respond to those kinds of concerns than our first witness this morning, Dr. Tyson, who is the chair of the Council of Economic Advisers. She is well-known to all the members of this committee. She previously appeared here to describe for us the important economic problems created by our current health care system. Today, she returns to discuss how the President's program will address these critical problems and to answer questions on the economic implications of the President's plan.

I will have my written statement included in the record in its entirety.

[The prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR KENNEDY

The President has proposed a bold plan to achieve comprehensive reform of the American health care system and provide affordable health security for every citizen. The plan could also have a significant impact on the economy. Health care accounts for one-seventh of total national spending.

The high cost of health care is a problem not just for families, but for business, federal, state and local budgets, and for the economy as a whole. The federal deficit is in large measure driven by

excessive inflation in health care spending. In fact, if such spending were held to the same rate of growth as the rest of the budget, we would cut the federal deficit in half in just five years. Restraining the growth in health spending as the President's plan progresses is an essential part of a strategy to revitalize the economy. At the present time, soaring health costs are eating up funds needed to finance investment, job creation, and economic recovery.

In many ways, it is small businesses that suffer the most from the current system. Insurance companies charge small businesses a premium mark-up that makes coverage far more costly than large businesses have to pay. For the smallest businesses, up to fifty cents of every premium dollar stays with the insurance company to cover administrative and sales costs and profits, rather than paying for essential health benefits.

Any program as comprehensive as the President is proposing will have substantial economic impacts beyond the health care system. These impacts deserve careful assessment.

As with any major reform, special interests opposed to the reform will produce excessive estimates of the alleged economic harm that will be done if the reform is adopted. In recent years, we have seen that tactic with the minimum wage, with the Family and Medical Leave Act, and with the Americans with Disabilities Act. The challenge facing Congress is to weigh all aspects of the change, including the economic impacts, as accurately as possible, and to compare them with the cost of doing nothing, or doing something ineffective.

Our hearing today will explore these issues. There are legitimate differences of opinion about the impact of some aspects of the President's plan. I welcome our witnesses, and I look forward to their testimony.

The CHAIRMAN. Dr. Tyson, we remember very well your appearance here earlier, when you spoke about some of the pressures that exist on our economy because of the health care costs, and today we are very interested in hearing from you again about how you view the President's program and what its impact is going to be on the economy, on employment, and on the other economic indicators.

We very much appreciate your presence here this morning.

We are currently in the process of a vote, but our other colleagues will be here momentarily, so I think we should get started with your presentation.

Before we begin I have statements from Senators Dodd and Mikulski.

PREPARED STATEMENT OF SENATOR DODD

Mr. Chairman, today's hearing—the sixth this fall on health care reform—focuses on issues of great importance—the impact of proposed reforms on jobs and the economy.

Without question, assuring health security to all Americans is among our highest priorities, along with employment and economic security. The relationship between these priorities must be examined carefully throughout the health care reform debate, so as not to ensure one at the expense of the others.

However, as we analyze the economics of proposed changes to the system, we must also keep in mind the economic impact of the current system and the consequences of failing to achieve reform on

jobs, businesses, and international competitiveness. We must not allow unsubstantiated fears to keep us from enacting meaningful reform and needed change.

Current system—what we know

We know that our current health care system has a negative effect on the economy. The first indication of the problem is the increasing percentage of profits absorbed by health care. In 1980, health care consumed 41 percent of after-tax profits. By 1991, it consumed 97 percent.

Our current system forces major manufacturers to spend far more on health care than their international competitors. We know that the U.S. automobile industry pays more for health care than for steel and that on average, they pay about $500 more per car on health care than the Japanese. The U.S. spends 14 percent of GDP on health care, while Japan and Germany spend closer to 8 percent.

The current system also has had a negative effect on workers' wages. Labor has foregone wage increases for health benefits. And employers' contributions to health insurance absorbed more than half of workers real income between 1973-1989. A significant portion of the premium includes the cost of care for those without health insurance.

So we know that without action, health care system will continue to hurt the U.S. economy. The question that follows is what effect will change have?

Will the plan hurt us economically?

At present, there is no evidence that the Clinton proposal will result in lost jobs or that it will hurt the U.S. economy. We have heard that the job losses predicted by several economists have been based on incorrect assumptions. And as recently as last week, when this committee heard from businesses and workers, both the U.S. Chamber of Commerce and the National Federation of Independent Business conceded that the previous estimates of job losses did not take into account the plan's proposed subsidies for business nor the schedule for phasing in coverage.

The draft plan's provisions to control escalating health care costs, make coverage affordable to smaller businesses, and prevent cost shifting on their face appear to be steps toward improving the current situation. but we will need to explore these issues more as we move forward in the debate.

Hawaii

I am interested in hearing more about Hawaii's experience with employer mandated coverage. Hawaii has had mandatory coverage for close to two decades. While significant differences exist between Hawaii and the experience other States might have under a similar system, Hawaii's experience with mandated coverage has been a positive one. The Hawaii example is not theory or fantasy. It's real world experience and warrants our attention.

Dr. Lewin, director of Hawaii's State Department of Health, is here with us this morning and I'd like to welcome him. When he

testified before this committee in 1989, he told us that Hawaii's system has not hurt Hawaii's businesses.

In fact, he and others have found that businesses who provided insurance before the mandate have benefited. They no longer foot the bill for the uninsured who worked for businesses that did not provide coverage. Hawaii's system has lowered the cost of coverage to small businesses, who sometimes pay as much as 40 percent more for insurance than larger businesses. I look forward to hearing more about the Hawaii experience this morning.

In closing, I want to welcome and thank our witnesses who will share with us their analysis of the administration's draft proposal. I hope that as we see and debate actual legislation, they will continue to provide their expertise to the committee.

PREPARED STATEMENT OF SENATOR MIKULSKI

Good morning Mr. Chairman, I want to begin by thanking you for holding this hearing.

It would be a major understatement to characterize the issue we are going to deal with today as very important. The economic impact of health care reform is second only to the health impact itself in terms of the need to address this problem.

As I've said before, it is not just the health of our people at stake in this debate, its the health of our economy as well.

Everyone who is party to the deliberations about health care reform should be vitally interested in today's testimony.

After hearing from the people of Maryland, it is clear to me that our economy is among the chief victims of the mess we are now in with health care in this country.

I've heard too many stories about exploding costs that have hurt both employers and workers, and too many stories about people losing coverage and ending up economically devastated because of a medical need. The need for action is clear.

Mr. Chairman, you told a story the other day which really made me stop and think.

It was about testimony you heard from a mother who had to tell her kids that they weren't allowed to ride their bicycles because of the chance they might fall. This family did not have the protection needed to pay for a broken arm.

This is not the America we have known.

This is not the America we should aspire to.

People who play by the rules, people who work hard and pay their taxes and serve their country when called upon, shouldn't have that kind of fear.

That kind of fear results in an insidious loss of liberty.

We need the kind of health care reform which will end that kind of fear forever, while constraining costs in a way that supports rather than undermines our economy.

A major question for everyone involved in this debate is: "How many jobs will be affected by this initiative?" "How many will be lost?" "How many will be created?"

I know I'd like to see reliable information on that question.

But we also have to recognize that we have already lost too many jobs to the status-quo. And many more jobs will be lost if we don't do something to fix it.

If all we were worried about was the economy, we would still need health care reform. As it is, this system imposes what I call a "value subtracted" tax on every American product. The exploding cost of health care is hurting business, hurting workers, and making us less competitive in the global marketplace.

We heard testimony last week from the Ford Motor Company about just that problem. That testimony told of a hidden $1000 "value subtracted" tax on every American made car because of the cost of health care!

I've been talking to Marylanders about the economic impact of health care reform, and let me tell you they are plenty worried. But what they are most worried about is the economic impact of no health care reform.

Let me just share a couple of facts from my state.

> In 1980 a large employer in Allegheny County paid 5% of its total payroll for health care premiums. By 1992, that same company paid 11.3% of payroll.
>
> That is astounding enough, but to make matters worse, the more they paid the less they got.
>
> Deductibles were up, copays were up, covered services were down, and employees had to pay 20% of the price (compared to none in 1980).

And the impact of these cost increases on employees has been worse than the impact on employers.

> If things don't change, by the year 2000 almost $1 of every $5 earned by the average Marylander will go to health care spending. This compares to 30 cents in 1970, and 65 cents today.

One last fact that I found most disturbing and have cited before because of its importance. It speaks volumes about the priorities of our society and also about how well the public and private sectors constrain costs in an area of critical importance.

> In 1970, the people of Maryland spent just about the same amount on education as on health care. Today we spend twice as much on health care.

Mr. Chairman, we need to turn that record around.

I hope that this hearing will shed important light on how to do that. We need to both understand the impact of the reform the President has proposed on our economy and how we can move our nation away from the destructive path we have been following.

When I think of all of our country's many needs which remain unaddressed, I am convinced that we can no longer afford the status-quo.

Mr. Chairman, I have never been more serious about anything than what I am about to say. Problems as fundamental and complex as this is what we were all sent to Washington to address. And the time to do it is now.

I look forward to the testimony to be provided today.

Thank you Mr. Chairman.

STATEMENT OF LAURA D'ANDREA TYSON, CHAIR, PRESIDENT'S COUNCIL OF ECONOMIC ADVISERS, WASHINGTON, DC

Ms. TYSON. Thank you very much, and thank you for the opportunity to speak about our health care system and our proposed reform. It is really a pleasure and an honor to speak with this committee and with you, who have spent so much time thinking about this very important issue for our country.

I want to briefly summarize some of the problems I spoke with you about the last time, just so that we can have again in mind the shortcomings of the system that we are trying to reform.

The system we are trying to reform has many shortcomings which have important economic effects, and I just want to summarize what they are.

First of all, the current system does not provide security for many Americans. When people get sick, the cost of their insurance can increase dramatically and unexpectedly, or they can be dropped from coverage altogether. This is really a situation which is the result of risk selection practices on the part of insurers. While it makes sense for any individual insurer to behave this way, it does not make sense from the point of view of the economy and what insurance is supposed to do.

The second problem with our health insurance system is it distorts the employment decisions of individuals. Since almost 40 percent of insurers exclude pre-existing conditions from their coverage of newly-insured people, many individuals feel locked into their current insurance policies and their current jobs. Up to 30 percent of employees in surveys report that they feel locked into jobs. They feel they cannot move to other jobs, and they feel a disincentive to start out on a new small business on their own because of the cost of getting insurance. People feel locked into welfare because to go off of welfare risks Medicaid coverage if they take a job.

So if we are to have a flexible work force, if we are to have a matching of individuals' skills and talents with job opportunities, we must end job lock and welfare lock, which come out of our insurance system.

The third problem with the current system, of course, is that the number of people who cannot find affordable insurance is very large and expanding. Over 37 million Americans do not have health insurance, and this is not a predicament of the unemployed alone. Three-quarters of all uninsured people are in working families, and over one-third of all uninsured people are in families with at least one full-time worker.

So we have a system which simply cannot deliver insurance even to working Americans.

Now, it is a myth that the people who have insurance do not have to worry about the uninsured, because when the uninsured incur health care costs, the insured pick up the bill. Currently, the uninsured pay only about 20 percent of the costs they incur. The privately insured pay 130 percent of the costs they incur. That is about $25 billion in uncompensated care paid for by the insurer.

The fourth problem with our system, of course, is that our costs are very high and rising rapidly. No other country in the world spends more than 10 percent of its GDP on health care. We spend

14 percent. American consumers spend more on health care than fuel oil, electricity, natural gas, oil and gasoline, local transportation, furniture, and other household equipment combined.

There have been reports—there was a report yesterday—that health care inflation has shown some signs of moderation. Let me emphasize that during the last quarter, health care inflation was still three times as rapid as overall consumer price inflation. During the last year, medical prices have increased at a 5.7 percent annual rate, compared to an overall CPI increase of only 2.7 percent. So our costs are high, and they are continuing to rise rapidly.

Health care spending per worker in the United States in our current system will be over $7,000 per worker in 1994. American workers on average pay $1,864 directly for health care. Their employers spend an additional $3,409, and Federal, State and local taxes for health care amount to $2,149.

Now, what we know from empirical research is that this heavy weight of health care cost per employee shows up in part by employers responding with lower wage growth. So if employer contributions to health insurance had remained the same share of compensation as they were in 1975, American workers today in real terms would earn $1,000 more. It is basically the case that health costs have been gobbling up more and more of the real wage possibilities of the American work force.

Finally, the fifth problem in our system is that it is riddled with waste, excess supply and inefficiencies. Despite our massive commitment of resources to health care spending, the United States ranks 19th out of 26 countries in infant mortality and 18th in life expectancy. We lose an estimated $80 billion a year to fraud and abuse, $45 billion a year is spent on administrative expenses and paperwork, and over one-third of medical procedures are judged in studies to be unnecessary or inappropriate. Hospital prices continue to rise in many parts of the country despite the fact that beds are in excess supply. And finally, HMO experience from my State and many other States indicates that you may be able to reduce the cost of medical care by 10 to 20 percent without reducing the quality of outcome.

There are a number of diverse indicators which paint a very compelling picture that we have waste and inefficiency in our health care system. For an economist, that is perhaps the main reason to reform the health care system. If you have one-seventh of the economy riddled with inefficiency and excess resources, the standard of living of the entire economy can be brought up by reforming and getting rid of this waste and inefficiency.

Now, those are the problems. What will our health security plan do? What are the major economic effects?

First of all, the employers who currently offer health insurance will see their costs fall immediately. Under our health care security plan, every individual will receive health insurance. What will this mean for those companies that are currently providing insurance? Eliminating uncompensated care will lower costs to businesses that currently provide, thereby making resources in those businesses available for higher wages, more investment, more research and development, higher profits, lower prices—a variety of things.

In addition, businesses that provide will be benefited also by eliminating corporate free riders. That is, there are many companies that currently provide health benefits for their employees and for the spouses of their employees. If those spouses are working, in our system, their employers will cover their health care costs.

So we will eliminate uncompensated care and eliminate corporate free riders. That will help companies that are currently insuring.

Second, we have done estimates indicating that as a result of our plan bringing the rate of growth of costs down over time, by the end of this decade, aggregate business spending—that is, total business spending on health insurance—will decline. In fact, at the end of the decade, our preliminary estimates indicate that aggregate business spending on health care services provided by the health security plan will fall by $10 billion.

As I said, businesses can do many things with the resulting savings, and they are all beneficial for the economy. They might decide to use the savings to increase employment. They might decide to use the savings to increase wages. They might decide to reduce prices. They might decide to invest more.

Each of these outcomes which come from the business community as a whole spending less on health care is a beneficial outcome for the economy and for employment.

I want to emphasize, as I think the press and the American public are beginning to understand, that small businesses will be particularly benefited from the health security plan. Currently, small businesses that provide insurance face administrative costs of up to 40 percent, while large business administrative costs are only 5 percent.

Under reform, the administrative costs alone for the small firms will fall by up to 25 percent. Additionally, many of the small insuring firms will receive discounts on their premiums. Right now, the system really works to the disadvantage of the small firm. They pay up to 35 percent more for the same insurance as big companies, and the rate of growth of health insurance for small business has been 50 percent faster than the rate of growth of health insurance for big business. So this will be a benefit to the small business community.

Although small businesses that do not currently provide insurance will indeed pay more, they are very likely to receive health care discounts. We have designed a system of discounts which precisely reflects the reality that small firms that do not now provide insurance should get a discount—should get an affordable package of insurance.

Many small businesses have reported in surveys that they wish to provide insurance, but that they cannot find affordable insurance. In one study done for the National Federation of Independent Business, Charles Hall of Temple University found that 64 percent of small business owners would like to provide some or better insurance for their workers. When they are asked why they are not doing so, they say because the premiums in the current system are too high. Yes, they are too high, for all the reasons I suggested before. Small firms are at a disadvantage.

Under our health security plan, small firms will be able to get affordable insurance, and the discounts will make sure that is the case.

The health care security plan will also have an effect on the health care sector in many ways. In particular, I would argue it would make it more efficient, but it also will actually in the short run increase employment. You have to think about the plan as initially bringing more people in, a net increase for health care services, and then bringing down the rate of increase of health care spending over time, slowing it down over time.

We estimate that the net effect of this in the short run, by the end of the decade, we should have something like 400,000 additional new workers in the health care sector.

Over time, of course, the health care sector will become more productive, but that does not mean—and again, I want to emphasize there is some confusion sometimes—we do not anticipate at any time a decline in health care sector employment. If anything what we are saying is there is an increase in health care sector employment initially, and then it grows more slowly over time. Sometime in the future, relative to baseline employment, we may have less health care sector employment, but there is not an absolute decline in the number of workers in the health care sector.

Another economic effect which will be very beneficial is the reduction of job lock and welfare lock. As I have indicated, workers feel right now that they are locked into their jobs for fear of losing their health insurance. Welfare families feel they are locked in welfare for fear of losing their health insurance, their Medicaid coverage.

We believe that the additional flexibility will allow workers to pursue more productive careers, will allow a better match between employers and employees, and this will improve efficiency in the economy.

It should also be emphasized that some workers may decide in a changed health care system to retire early as a result of health care reform. This voluntary increase in retirement may in fact increase employment opportunities for younger workers.

Now, I have painted so far the beneficial picture. Nonetheless there are some studies out there that claim that the health security plan will cause substantial damage to the economy, and I want to try to indicate what I believe to be wrong with the existing approaches and existing studies.

First of all, it is important to begin by emphasizing that some firms and some individuals will in fact pay more for health insurance than they did prior to reform. We know that the health security plan will increase costs for some young, single workers and will increase health insurance costs for some firms that did not previously offer health insurance. Both of those things are true.

The vast majority of American families and American workers, however, will benefit from a reduction in health insurance costs, from having portable health insurance coverage, from having a reduction in the job lock that currently makes them less flexible. Then, in addition, as I noted, many employers, both large and small, who currently provide insurance will initially benefit right

off the bat, an immediate benefit, and the business sector as a whole will benefit within 3 years of the plan's full implementation.

So what do the studies have to assume, or what do they miss, to get a negative effect? Given that I have just indicated all the reasons why the effects are positive, what do the studies have to assume to get a negative effect?

There are several studies. One study in particular, by O'Neill and O'Neill, which has been the most widely cited study, which suggests that the job number may be as many as 3.1 million jobs lost, is a study that is riddled with inaccuracies about our plan and what our plan actually is and with also questionable analytical assumptions.

As to the inaccuracies on our plan, this study does not account for any of our discounts. As I said, we have put into our plan discounts for small, low-wage firms, precisely to deal with the reality that many of these firms currently do not provide insurance. So we are giving a discount to them, and the study overlooks that.

The study also overlooks the fact that the costs for the firm will depend upon the part-time or full-time nature of the worker, so this will be a pro-rated premium for part-time workers, not a full premium for part-time workers.

This study also vast overestimates the cost of the premium. They use a premium of $5,310 per worker and a family, and $2,160 for a single worker. The estimates of our health security plan, which have been signed off by a number of actuaries, are $2,500 per worker and a family, and $1,500 for a single worker. So these are the more realistic estimates of what our premiums will cost.

Those are the factual errors. Now the analytical errors. Any study which tries to estimate the employment effects of health care has to make a decision about how sensitive firms are to a change in their employment costs. So some firms will see their employment costs going down; those are firms that are already providing insurance and are going to get a better deal. Some firms will see their costs going up. In order to judge the employment effects, you have to make an estimate of how sensitive the firm is to changes in those costs.

The O'Neill study, for example, assumes that firms that see their costs increase by 10 percent will lay off 3 percent of their workers. We looked through the economic literature on this, and the estimates in the economic literature suggest that the employment response may be only one-sixth to one-third as large. That is, they are making a very out-of-range, in our view, assumption about how sensitive firms are in their employment decisions.

Finally and most importantly, the existing studies that are out there do not really allow for any new job creation in businesses whose costs fall as a consequence of our reform. That is, most of the studies ask the following question: Suppose the only effect of our plan were an increase in insurance costs for some firms. What would be the effect on employment? That is the wrong question. It is the wrong question because many firms will see a decline in their costs, and the overall business community will see a decline in its costs. So you actually have to ask a much more complicated set of questions where many firms are actually benefiting.

Finally, if you just look at the real world evidence from Hawaii, of course, the suggestion that job loss claims in studies like O'Neill do appear to be exaggerated. Hawaii imposed an employer health insurance mandate in 1974. Since the 1970's, total private nonfarm employment has grown by 80 percent in Hawaii, compared to 54 percent in the Nation as a whole; and retail and wholesale trade employment have grown more in Hawaii than in the Nation as a whole.

I understand that you will be hearing from Dr. Jack Lewin later this morning. He certainly understands and can explain Hawaii's experience with a health care mandate.

Now, where does that lead us in terms of a summary conclusion on the likely effects of health care reform? We believe that neither the models nor the data are available to yield a precise estimate of the employment effects of health care reform. In many areas of economics, there are models that allow economists to make a prediction and have a reasonable amount of faith in their prediction. For example, if you asked me what the effect of a particular spending cut is on economic performance at the aggregate level, I can use a standard model, the Wharton econometric model or the DRI model or a number of models out there, and make a prediction. The model is designed precisely to answer that question. I can make the prediction and give you a prediction with a reasonable range of accuracy.

There are not any existing models that allow us to do that in answering the question of the employment effects of health care reform. This is because the appropriate model, the model you would need for such an exercise, would have to make distinctions between firms that currently provide insurance and firms that currently do not provide insurance; between large firms and small firms. They would also have to make distinctions among the various ways that a firm can respond to a change in health care costs, whether it is an increase or a decrease. Firms can do many things. The model would also have to predict how individuals will respond. Will individuals change their behavior in terms of deciding to start a new business, deciding to retire, deciding to move jobs more frequently, deciding to go off of welfare?

There is simply no model around which allows you to take into effect all of these very important incentive questions about our health care reform. In the absence of such a model—and no one has such a model; I want to emphasize this—one can generate either small net positive or small net negative effects on employment with existing models depending upon what you assume. It is sort of the old adage that you get out what you put in. I can put in a set of assumptions that will generate employment gains that are perfectly reasonable. I can put in a set of assumptions that will generate employment losses.

The net effects are small. Not surprisingly, therefore, several private sector economists have concluded as we at the CEA have concluded, that the net effect of our health care plan on aggregate employment is likely to be small.

What we suggest on the basis of a series of internal runs is a range of plus or minus one-half of one percent at the aggregate em-

ployment level. That is plus or minus one-half of one percent at the aggregate employment level.

What is the intuition here? Why is it plus or minus? Because there are some factors in the plan that will encourage employment, for example, by firms that are better off because their health care costs are coming down or because we may have greater job mobility into self-employment or something like that. There are factors that will tend to decrease employment—a firm facing higher costs might in fact decide to adjust its size.

These offsetting factors tend to cancel out. What we know for sure is that the composition of employment is likely to change; that over time, the factors encouraging an increase in employment will get stronger because business sector spending will come down; and on balance, the net effects are small.

Therefore, as an economist I conclude that the net effects on employment per se are likely to be small, but this is clearly a very important, good plan for the American economy. We know this with certainty. It diminishes job lock, it diminishes welfare lock, it allows more people to be self-employed, it gets health care costs under control, it guarantees security to all Americans, it reduces waste and inefficiency in one-seventh of our economy.

If we reorganize our health care system, we can use our scarce resources more efficiently to help us realize the goal of higher living standards for ourselves and our children.

I would be delighted to answer any other questions you have about the economic effects of health care reform, and I look forward to working with you to make sure we reform the problems in our current system.

Thank you.

[The prepared statement of Ms. Tyson follows:]

PREPARED STATEMENT OF LAURA D'ANDREA TYSON

THE ECONOMIC EFFECTS OF HEALTH CARE REFORM

Thank you, Mr. Chairman, for the opportunity to come before your Committee to discuss the economic effects of health care reform.

The United States is facing a health care crisis. The rapidly rising cost of health care hurts businesses, depresses wages, and contributes to fiscal imbalance. The average working American will be charged, directly and indirectly, over $7,000 for health care in 1994. The lack of health security makes many individuals afraid to leave their current jobs, discourages others from working for small businesses or becoming self-employed, and keeps people on welfare instead of working.

Reforming health care is a difficult challenge, but one that we must face. Let me first outline the problems that force us to take action, and then I will move on to the economic effects of the Health Security plan.

Why Reform Health Care?

There are five reasons why urgent health care action is needed.

The First problem is that our health care system does not provide security to individuals. When people get sick, the cost of their insurance can increase dramatically, or they can be dropped from coverage completely. This situation is a result of risk selection practices on the part of insurers. Insurers spend large amounts of money trying to select good health risks, and avoid bad risks. This practice is profitable for any one insurer but is socially wasteful. After all, someone must cover the costs incurred by people who get sick. The result is that many people cannot get coverage, and many more fear for their ability to get coverage in the future.

The second problem with our health insurance system is that it interferes with the employment decisions of individuals. Almost 40 percent of insurers exclude prexisting conditions from their coverage of newly insured people, thus locking many people into their current insurance policies and jobs. Up to 30 percent of em-

ployees feel "locked" into their jobs. Others do not form small businesses or become self-employed because of the difficulty of obtaining insurance. Finally, many people remain on welfare because they will lose their Medicaid coverage if they take a job. If we are to adapt to changing domestic ad international economic circumstances, we must not penalize people every time they change or lose a job.

The third problem with our health care system is that the number of people who do not have access to affordable insurance is large and expanding. Over 37 million people do not have health insurance. And this is not a predicament unique to the unemployed. Three-quarters of all uninsured people are in working families, and over one-third of the uninsured are in families with at least one full-time year-round worker. We have a system in which millions of people, many of them in working families, cannot afford the rising costs of health care coverage, and they face the risk of being financially crippled by events beyond their control.

It is a myth that insured people do not need to worry about the uninsured. Under our current system, when the uninsured face catastrophic costs, the insured pick up the bill. Currently, the uninsured pay only 20 percent of the health care costs they incur, while the privately insured pay 130 percent of their actual health care costs. According to recent estimates, there will be about $25 billion of "uncompensated care" paid for by the insured in 1994. Providing health insurance for all Americans could therefore lower premiums for the currently insured by over 10 percent.

The fourth problem with the health care system is that health care costs are high and rising: No other country in the world spends more than 10 percent of its GDP on health care. The United States spends 14 percent. American consumers spend more on health care than on fuel oil, electricity, natural gas, other household operations, oil and gasoline, local transportation, furniture, and other household equipment combined. Even though health care inflation has moderated recently, during the last quarter it was still three times as rapid as overall consumer price inflation.

Health care spending per working American will be over $7,000 per worker in 1994. American workers will, on average, pay $1,864 directly for health care in 1994. Their employers will pay an additional $3,409. And Federal, State, and local taxes for health care will total $2,149.

Empirical research suggests that businesses generally respond to higher health care costs by lowering the wages they pay to their employees. Similarly, the taxes required to pay for government health spending are borne to some extent by workers in the form of lower wages. Thus, if employer contributions to health insurance had remained constant at their 1975 share of compensation through 1992, and if employers had passed these savings on to workers, real wages per worker would have been over $1,000 higher in 1992.

The fifth problem with our health care system is that it is riddled with waste, excess supply, and inefficiencies. Despite our massive commitment of resources to health care spending, the United States ranks 19th out of 26 countries in infant mortality and 18th in life expectancy. We lose an estimated $80 billion a year to fraud and abuse. Over 5 percent of our total health care spending—conservatively $45 billion in 1992—covers administrative expenses and paperwork. As many as one-third of common medical procedures may be unnecessary and inappropriate. Hospital prices continue to rise even though hospital beds are in excess supply in many parts of the country. HMO experience indicates that the cost of medical care can be cut by as much as 10-20 percent without reducing the quality of care.

These diverse indicators paint a compelling picture of the inefficiency and waste in our current health care system. Perhaps the most important economic reason for reform is to improve the efficiency of this system. This in turn will make resources available to cover the uninsured and to address our other pressing economic and social needs.

The Economic Effects of Reform

The Health Security plan addresses these fundamental problems with the current system. It will lower costs, provide security, increase job opportunities and increase the efficiency of the economy. Many businesses will see their costs fall, and many others will have access to coverage previously denied them. Slower cost growth will allow workers to enjoy faster growth in their real wages, and reduced job lock will increase workers' ability to find better jobs. Let me describe what I believe to be the important economic effects of health care reform.

First, many employers who currently offer health insurance will see their costs fall immediately. Under the Health Security plan, every individual will receive health insurance. Eliminating uncompensated care in the current system will lower costs to businesses that provide care, thereby making resources available for increased wages or additional hiring. Eliminating corporate "free riders" will also re-

duce spending by companies that currently provide health benefits for their employees and for their spouses who are not covered by their own employers.

Second, the Health Security plan gradually lowers aggregate business spending on health insurance. Although the business sector as a whole will initially pay more for health insurance, the reduction in health care cost growth lowers the growth of premiums over time. In fact, by the end of this decade, preliminary estimates indicate that aggregate business spending on services covered by the Health Security plan will fall by $10 billion.

Businesses can do many things with the resulting cost savings. They can: hire more workers; raise wages or provide better benefits for existing workers; invest in more plant, equipment, education and training, and research and development; increase dividends to shareholders; or lower prices, thereby leaving consumers with more income to spend on other goods. Each of these outcomes will have a stimulative effect on the economy and will increase employment. Economic research has not reached clear conclusions about how to apportion the savings among these effects. Almost all models suggest that wage increases are a likely response, but they differ about whether all of the savings will flow into wage increases. Nevertheless, the effects of lower health care spending are clearly beneficial for the economy.

Small businesses will particularly benefit from the Health Security plan. Currently small businesses that provide insurance face administrative costs of up to 40 percent, while large businesses face costs of only 5 percent. Under reform, administrative costs for small firms will fall by up to 25 percent. Additionally, many of those currently insuring small firms will receive discounts on their premiums.

Although small businesses that do not currently provide insurance will pay more, they are likely to receive discounts to make health care affordable. There is a common myth that small businesses cannot afford to pay anything for health insurance. In fact, many small businesses report they would like to provide health insurance for their employees if it were more affordable. According to a recent study for the NFIB performed by Charles Hall of Temple University, 64 percent of small business owners would like to provide some or better insurance for their workers. When asked why they do not offer insurance, the most common response (65 percent) was that premiums are too high. Ninety-two percent of small business owners agree that the cost of health insurance is a serious business problem. Under the Health Security plan, with affordable health insurance and discounts for small businesses, this will no longer be the case.

Third, the Health Security plan will result in greater employment in the health care sector in the short run and a more efficient health sector in the long run. With the increase in the number of insured Americans and the decrease in the administrative burden of health insurance, there will be a significant expansion of employment of health care providers and a decrease in employment of health administrators and insurance workers. By 1996, as many as 400,000 net new jobs will be created in the health sector. As the cost savings of the plan begin to accrue, employment in the health sector will grow more slowly, although there will be no absolute decline in the number of employees.

Over time, the health sector will become more productive. This benefits all of us. We will be able to have the same or better health care as well as more investment, research and development, or just plain goods and services.

Fourth, the efficiency of the economy will also be increased by reducing job lock and welfare lock. By providing health care security, the reform will give workers the freedom to move to jobs where they might be more productive without having to worry about losing their health insurance. Small firms should particularly benefit from this, since they often have the hardest time attracting highly skilled workers. In addition, firms should be more willing to hire workers with pre-existing conditions because the new system does not penalize individuals with a prior illness. This allows for better, more efficient matches between employers and employees and increases the efficiency of the economy.

Some workers may decide to leave the labor force completely when there is continuous health coverage. Evidence suggests that about 350-600,000 people will decide to retire early under health care reform. This increase in voluntary retirement may increase employment opportunities for younger workers.

The Shortcomings of Existing Studies on the Employment Effects of Health Care Reform

As you know, some have claimed that the Health Security plan will cause substantial damage to the economy. There is no denying that some firms and individuals will pay more than they did prior to reform. In particular, the Health Security plan will increase Costs for some young, single individuals as well as for firms that did not previously offer health insurance. The vast majority of Americans, however,

will benefit from the reduction in health insurance costs, the portability of coverage, the lower administrative costs, the reduction of job lock, the lower costs for small businesses and the self-employed, and the reduction in welfare lock. In addition, as already noted, many employers, both large and small, currently providing insurance will enjoy lower costs immediately and the business sector as a whole will enjoy lower costs within three years of the plan's full implementation.

There are some studies, including an often cited study by June and David O'Neill, that criticize the Health Security plan as a job-destroyer. I believe these studies are riddled with error and inaccuracies. First, they completely overlook the discounts for small and low-wage businesses provided by the Health Security plan. The lack of discounts—coupled with the questionable assumption that Finns cannot shift any costs to workers earning less than $25,000 per year—lead directly to massively exaggerated estimates of job loss. Additionally, in the O'Neill study, employers are assumed to pay the full premium for all workers who work more than 20 hours per week. In the Health Security plan, however, employers pay a much smaller, prorated premium for part-time workers.

Second, the studies assume a premium for the benefits package that far exceeds the premium for the Administration's benefits package. The O'Neill study assumes that employers pay a premium of $5,310 per worker with a family and $2,160 per single worker. Estimates for the Health Security plan, however, suggest that employers will pay about $2,500 per worker with a family, and about $1,500 per single worker. These estimates take into account the fact that many families have two adults in the labor force, and that each working adult will have an employer contributing to health care coverage for the family.

These studies also assume that business employment decisions are three to six times more sensitive to increases in the costs of hiring labor than most conventional estimates. The O'Neill study, for example, assumes that firms will lay off 3 percent of their work force if employee compensation rises by 10 percent. Summary estimates in the economic literature suggest that the employment response might be only one-sixth to one-third as large.

Finally, and most importantly, the existing studies do not allow for any new job creation in businesses whose costs will fall as an immediate or dual consequence of reform.

In fact, real-world evidence from Hawaii suggests that the job loss claims in studies like the O'Neill study are exaggerated. Hawaii imposed an employer health insurance mandate in 1974. Since the 1970s, total private non-farm employment has grown by 80 percent in Hawaii, compared to 54 percent in the Nation as a whole; and retail and wholesale trade employment have grown by more in Hawaii than in the Nation as a whole. Although we cannot extrapolate from these results and make sweeping judgments about the national impact of an employer mandate, the experience of Hawaii appears to contradict the conclusions of studies suggesting that such a mandate will destroy jobs.

Additional evidence from recent literature on the effects of increases in the minimum wage on employment also calls into question such conclusions. We estimate that under reform the increase in health care costs for currently uninsured low-wage workers in small firms is equivalent to a very modest increase of $.15 to $.35 per hour in the minimum wage. This will leave the real compensation cost for minimum wage workers below its average level in the 1980s. Research by Lawrence Katz at Harvard and Alan Krueger and David Card at Princeton finds that recent increases in the minimum wage have had minimal or even positive effects on employment. These results lead us to conclude that the O'Neill study greatly exaggerates the effects of reform on the employment prospects of minimum wage workers.

Summary Conclusions on the Likely Economic Effects of Health Care Reform

Neither the models nor the data are available to yield a precise estimate of the employment effects of health care reform. In many other areas of economics, there are models that have been tried and tested for decades, and economists generally place a good deal of faith in the outcomes they predict. Standard macroeconomic models, for example, can make reasonably precise predictions about how a tax increase or a spending cut will affect aggregate output or employment.

But there are no existing models that allow us to predict the employment effects of health care reform with the same degree of precision. This is because the appropriate model for such an exercise would have to make distinctions both between Finns that currently provide insurance and those that do not and among the many ways that firms in either group might respond to a change in their health care costs. Such a model would also have to predict how individuals might respond to

new incentives in the plan, particularly those affecting small business creation, job mobility, welfare lock, and retirement.

In the absence of an appropriately specified model, one can generate either small net positive or small net negative effects on employment with existing models depending on the assumptions one is willing to make—demonstrating the old adage that you get out what you put in. Not surprisingly, several private-sector economists have concluded, as we at the CEA have concluded, that the net effect of our health care plan on the aggregate employment level is likely to be small—our internal estimates suggest a range of plus or minus one-half of 1 percent of the aggregate employment level. This is because although there are some factors in the plan that will tend to decrease employment, there are others that will tend both to increase employment and to change its composition. These offsetting factors are likely to cancel each other out, although over time as business spending falls below baseline, the factors encouraging an increase in employment are likely to strengthen.

On balance, I am certain that the Health Security plan is good for American business and the American people. It diminishes job lock and welfare lock and allows more people to become self-employed. It gets health care costs under control. It guarantees security to all Americans. And it reduces waste and inefficiency in one-seventh of our economy. Reorganizing our health care system to use our scarce resources more efficiently will help us realize our goal of realizing higher living standards for ourselves and our children.

I will be delighted to answer any questions that you may have at this time.

The CHAIRMAN. Thank you very much for an excellent presentation.

We will have 7-minute rounds for questioning, and I will ask the staff to watch the time and notify the members.

If we do nothing at all—you pointed out we are at 14 percent now, 14.3, 14.4 percent, and there is no other country that is above 10 percent, and most of the other industrial countries are under that—if we do nothing at all, what is your projection now through the end of this century, for the next 5 or 6 years?

Ms. TYSON. Our projection now is that we will go up in the year 2000 to $1.63 trillion spent on health care, or 18.9 percent of GDP—and that is with no coverage of any additional person.

The CHAIRMAN. So that is almost virtually double what we are spending at the present time, and you are drawing that away from all the other areas of spending in terms of goods and services.

It is interesting to me when people talk about the various figures and costs, I think what we ought to understand, as I think the President stated very well, is that that is a completely unacceptable alternative, just doing nothing at all, because its impact and what it would mean in terms of cost to the economy, cost to business, cost in profits and cost in human suffering is dramatic.

Now, people ask can we really expect to believe with the 37 million people who are not covered, and with the kind of preventive program which is included in the President's plan, which would be the most extensive, really, of any insurance programs—a few percent of total insurance programs may include them, but certainly not for the most part I think one of the very strong aspects that has great appeal, as we saw yesterday, is the President's strong commitment on breast cancer and all of the implications in terms of preventive health care measures. Do you think we will be able to cover those individuals who are not covered and also provide those services I just referred to only with increases in sin taxes?

Ms. TYSON. Well, I think that you have to begin with a recognition of the extent of inefficiency and misallocation in the current system. I think one of the reasons people are grappling with how

can we cover all of these uninsured and rely simply on a sin tax—I think the answer really lies in how the current system works.

First of all, people who are uninsured do get services. They get them in the most expensive possible way. And when they get them in the most expensive possible way, those costs then fall on the insured. So if the uninsured pay 20 percent of the health care costs they currently incur, and they are incurring the high-cost parts of the health care system, that results in $25 billion of uncompensated care.

So the first thing is that we are covering people, and we want to cover them in a much more cost-effective way.

The second thing to emphasize here is that when you think about what we are suggesting, we are suggesting that by the end of this decade, when all is said and done, we are looking for a system which through reform might generate savings of $136 billion. That is less than 10 percent of total projected spending for the year 2000.

Where will these savings come from? I have already indicated that we have a lot of areas for improvement. We have the $80 billion of fraud and abuse, we have the $45 billion of administrative expenses. We have the fact that was pointed out by Professor Rinehart in Monday's editorial, that in some parts of the country—in San Francisco, which I know to be a high-cost city, doctor spending per Medicare beneficiary is in the order of $894 a year. In Miami, also a high-cost area, but certainly no higher-cost than San Francisco, it is $1,000 more a year. There is something clearly amiss with the current system. There are resources that are misallocated, that are being wasted.

You have the other piece of evidence, which for an economist actually suggests that market forces are not all they could be in this sector of the economy. You have the phenomenon of excess supply of machinery and excess supply of hospital beds. Now, in situations of excess supply, prices should go down. If the market mechanism were functioning effectively, prices would go down. But prices continue to rise, and that does suggest again that if we had competitive pressure, we could serve a larger number of people for less.

Finally, let me just point out the HMO experience. Again, California has a lot of evidence in this regard. The HMO experience is that for the same quality care, we can have costs as low as 10 to 20 percent below current levels. So we believe that we can by reforming the system improve the allocation of resources, improve the efficiency of resource use, and cover those extra people—and cover them in a more effective way so they do not wait until the last minute to come to the emergency room.

The CHAIRMAN. An article in the Washington Post on Sunday said, "Economists have expressed concern that President Clinton's program would establish a large new entitlement of the kind that caused the current deficit problem."

How do you respond to that?

Ms. TYSON. I respond to that in a number of ways. First, I want to emphasize that the estimates that have gone into our health care planning process are, I think, the best available estimates. This has not been a quick process. This has been a process that has taken months, and during those months, my staff and the staffs of

all the major agencies involved went through every, single study, we talked to every major expert that we could find, we worked with the actuaries at HHS, we have worked with private sector actuaries. We came up with a set of numbers which we believe to be the best possible set of numbers around.

We believe that in the ongoing debate about health care reform which will continue that these should be the baseline numbers for anybody to start with. They may make different policy decisions, but the numbers themselves we believe to be sound.

So I really disagree with a number of the comments, including the one by my predecessor, that somehow these numbers are groundless. They are based on very serious research and the best possible evidence coming from some of the Nation's most important health care experts. So that is the first thing.

The second thing is we have built into our estimates some cushions. We understand that the world is an uncertain place and that there is no crystal ball, and there is no absolute precision. So we do have cushions built into our financing to reflect the fact—we have cushions built into our subsidy estimates.

Finally, of course, what I think is important to emphasize is that our global budget caps are essentially what we view as an emergency brake or a safety clause. We think that there is enough inefficiency and misallocation in the current system that the global caps will not be binding. But we do not want to sell the idea to the American people that ultimately there are no controls here and that we are getting ourselves into an uncontrolled program. We are not, because we are asking for a failsafe or emergency clause—global budget caps.

Finally, we are going to have a gradual phase-in here. We will be learning from the phase-in process. So I think we have done everything we can to start out with the best possible estimates and to build in safeties into all of our estimates and to build in a safety through the emergency clause.

The CHAIRMAN. My time is up.

Senator Kassebaum.

Senator KASSEBAUM. Thank you, Mr. Chairman.

Dr. Tyson, my apologies for missing your opening statement. We are having a hearing on Somalia right across the hall as well, and I am trying to balance the two, but I was particularly anxious to come and ask you a couple of questions on the estimates.

I think from past history, we have found out that estimating the cost of entitlements is enormously difficult and usually notoriously off-base. When we go back to Medicare Part A, it is about seven times higher than it was projected to be when it was passed in 1965; it went into effect in 1965. Medicaid was estimated in 1964 when it was passed to cost about $1 billion a year. It now costs about $76 billion a year.

So keeping that in mind, which I think is important to keep in mind, does it not concern you that the President is now proposing four really massive new entitlement programs, particularly in light of the fact that we have argued for some years over just being able to end wool and mohair and honey entitlements, which are minuscule compared to what we are talking about—the four being, of course, the guaranteed so-called Fortunate 500 benefit package for

everyone; the prescription drugs for Medicare; early retirement benefits; and the Federal payment of 80 percent for all retiree health costs.

I just wonder how you view this in the light of past history.

Ms. TYSON. OK. First of all, there are several things which occurred to me in your questions. Let me just begin with one point, which you ended with, about the generosity of the basic benefits package.

One of the reasons—the primary reason—for the package being a generous one is because of the clear evidence that if we are going to have the system behave more efficiently, if we are going to have people get care earlier when it is less expensive, or to get the most cost-effective form of care, which may often be drug care, we need to have a basic benefits package which encourages and allows people to make the most cost-sensitive decision at any moment in time.

So the more you go toward a more limited package, the more it seems to me that you reduce the incentive we want both providers and users of the system to have to use preventive least cost remedies rather than to wait for the most expensive catastrophic remedies. So that is just on the nature of why we went for the benefits package that we did.

As far as the general dangers of introducing entitlements, I again want to start with what I emphasized in my opening remarks. We have to look at where we are headed without doing anything. Where we are headed without doing anything is bringing 18.9 percent of our GDP into the provision of a very costly health care system without universal access, with 37 million Americans not covered.

So we are looking for a set of programs which will actually over time reduce the burden of health care spending on the economy, not increase it.

I think that we are aware, and I think we have all learned from the experience of the past. In designing this program, we were cognizant of the issue of needing to establish caps. So we do have—and it is criticized by some, but we believe it to be absolutely necessary—global budget caps for the private sector as well as for Medicare and Medicaid. We believe that we need to have a failsafe mechanism here so that the system does not spin out of control.

And I think, finally, what I also emphasize is that we have taken into account some of this problem already, for example, in our subsidy estimates by putting in a cushion to account for the fact that in any given year, there may be more unemployed people than we thought, or in any given year there might be some other reason for more subsidies than we thought.

So we are trying to deal with some of your concerns. But the issue comes back to do we allow what must be some residual uncertainty to stop us from acting, when the certainty of not acting we know to be detrimental.

Senator KASSEBAUM. Well, Dr. Tyson, first let me say I am supportive of a comprehensive health care reform plan. But my question to you is from the standpoint of an economist, the President is proposing—and I am not quarreling with the pros and cons of it, but just an acknowledge—the four largest entitlement programs

that have ever been proposed to Congress. Are you comfortable with the cost estimates and what will happen given the past history of what has happened to our entitlement programs?

Ms. TYSON. I am comfortable with the cost estimates, and I am comfortable with the cost estimates because I have been and my staff has been part of the process of putting them together. It has been a very careful process, and it has been a process where a wide range of experts have been involved.

Frankly, at the beginning, I raised the same questions. I think any economist would raise the same questions.

Senator KASSEBAUM. I would think so.

Ms. TYSON. It is part of the process of going through the estimations and bringing together the numbers and talking to health care experts like Professor Rinehart and others that I have become convinced that in fact the estimates of financing, the estimates of anticipated savings, the estimates of subsidies are not only credible, but they are cautious; they build in some cushions.

So I have become convinced, but it is an important question that everyone must ask, and I just hope that when people ask the question, they then spend a little time going through the evidence, as I have, and the evidence has convinced me.

Senator KASSEBAUM. That is true, but also keeping in mind the signposts from the past and what we estimated Medicare and Medicaid at the time.

My time is up, but I am sure there will be questions that will be asked regarding early retiree benefits, because essentially, isn't that extending Medicare to age 55?

Ms. TYSON. Do you want me to talk about the early retirement?

The CHAIRMAN. Yes.

Senator KASSEBAUM. Just whether you regard that as extending Medicare to age 55.

Ms. TYSON. I think the early retiree issue is best understood—there is a lot of talk about the early retiree issue, and I think one needs to understand that if we have a system of universal access, which we want, and if we have a system of community rating, which we want, then essentially there will be in our new system incentives for early retirement built in, because the cost of obtaining insurance as an early retiree will be brought down by both the universal access and the community rating of premiums.

So I do want to emphasize that to some extent if you want to deal with this issue—if you want to have universal access and you want to have community rating, you are going to bring down the cost of health insurance for age 55, and that will undoubtedly have some incentive for some workers to decide to retire early.

So that is the main issue in early retirement, and I do not think one can get around that main issue without undermining universal access and undermining community rating, and those are two basic principles of our system.

Senator KASSEBAUM. Thank you. My time is up.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Harkin.

Senator HARKIN. Thank you, Mr. Chairman.

Dr. Tyson, I apologize that I was not here for your opening statement, and I have tried to read through it. I just want to make one

point this morning, and it may seem like it is coming out of left field, but I think there is a glaring omission that people are not looking at in terms of this whole health care reform debate.

I was looking at your opening statement, and you were talking about the diverse problems that we have here. I think there is another problem. Let me first set the stage. I think it is well-known that a high proportion of our health care dollars are spent later in life. People are living longer, they are coming down with illnesses that they did not get before because they did not live that long—Alzheimer's, cancer, prostate, everything else.

Right now, we are spending on biomedical research in this country about one percent. Out of about $1 trillion in health care, about $10 billion goes into the National Institutes of Health. I may be wrong in my percentage, but it is one percent or less.

I am wondering if you or anyone else has looked at the economic impact of the lack of biomedical research in this country. For example, again, it is well-known that it is not just the technologies and so on that we develop, but finding the causes and cures for the illnesses that strike us. The research into the gene and gene therapy, the whole Human Genome Project that is now under way but is being inadequately funded. This just seems to be something that no one is talking about. And yet if we do not find the causes and cures for Alzheimer's disease alone, I do not care what kind of health care system you have out there, it is going to sink us, because the costs will be exorbitant, and they will continue to escalate as people live into their late eighties and early nineties.

Yet no one talks about medical research in medical terms. It is sort of out there on the side someplace. And I am going to continue to ask this question of you and of the people who come before us today, because we are asking about the economic impacts of health care reform—what are the economic impacts going to be if we do not find causes and cures and treatments for Alzheimer's and prostate cancer and breast cancer, most of the things that strike us later on in life. And what would the return be if we were to increase, for example, our funding in biomedical research by another percent? Instead of one percent or one-tenth of a percent, make it 2 percent or 3 percent.

I am just wondering why this has not been looked at, or have you looked at it? Have you made any judgments at all as to what would happen or what might be the payoffs in economic terms if we were to put more emphasis on biomedical research.

Ms. TYSON. Let me answer the question in two ways. No. 1, I agree with the notion that biomedical research—I would argue that spending on research and development through a wide part of our economy is critically important. And I think that the evidence about the returns to Government spending on both biomedical research, but also on other kinds of research programs in other kinds of technologies, the evidence is fairly strong, and actually, economists in general agree that the evidence is fairly strong that there are very high returns on this kind of Government spending.

Most economists who in general argue against Government spending will still make the case that in the area of research spending, the social returns can be double the private returns easily.

So I think that there is a very strong general argument, and there is evidence to support the argument, that additional funding for research has society-wide benefits, and biomedical research is obviously a very important part of our research dollars.

That is the first thing I would say. The second thing I would say is I think it is not enough in the following sense. We do not do enough research on the cost-effectiveness of therapies, whether they are equipment therapies or drug therapies. We need to have more research dollars on looking at alternative therapies so that we can make better-informed judgments over time about which therapies really are cost-effective and which are not. We are spending much too little on that part of research.

In part, we are spending too little on that part of research because our current health care system has no incentive to really ask the question very often, how cost-effective is this remedy or that remedy.

So we have a system in which every player in the system is engaged in passing the cost along to someone else, and not asking the question enough, is this a cost-effective therapy.

So in general my answer to you is it would be perfectly consistent with economic evidence that we spend more on biomedical research. I would like to see us spend some fraction of that on examining the cost-effectiveness of alternative therapies, and I would like to embed this in our health care reform system so that the incentives are there for using technology wisely.

Finally let me say that as a student of technology in other areas—I have not looked directly at the biomedical area, but I have looked at the computer area, for example, and the semiconductor area—as a student of technology in other areas, it has to be emphasized that technology is partly endogenous; that is, it moves along a path in response to market incentives. So right now, the incentive in our system is an incentive which does not ask many individuals to ask about the cost of the technology. You sort of look for the technology, you look for a cure, and you do not look for the cost.

So that presumably, by changing the system in which research is done, we may actually encourage technological breakthroughs that are much more cost-effective.

Senator HARKIN. I am glad to hear you talk about outcomes research, because that is a very important facet of it. But I want to get off the idea of technology, and I know there is some thought that technology does increases costs a lot of the time. I am talking more about the basic biomedical research into the structure of the cell and what happens at the cellular level, the whole Human Genome Project, mapping and sequencing the human gene and finding the gene therapies that can interrupt and stop these illnesses and diseases.

We are on the verge of that, but it will not happen unless we really focus more of our attention on research, and by that I mean put more money into it. That is why I wanted to get this out on the table about the economic impact of these researches.

I would just say that by the year 2000, we will have eradicated polio from the face of the earth. We have already done it for the North American continent. We are isolating it in a couple places

around the world now, but they are confident that by the year 2000, there will be no more polio on the face of the earth. Not only will that make people's lives better; it will save us in the neighborhood of about $250 to $300 million a year in this country alone in that we will not have to give vaccines to children any longer. So again, the savings over a period of time will more than make up for all the research that went into that.

Again, I want to emphasize that there would be some looking at the impact of that.

The second thing I wanted to say was that there are a lot of people talking about jobs that are going to be lost in the health care industry because of health care reform. But it seems to me that if we put more money into medical research, that will create jobs. It will do two things. It will create jobs, but it will create high-tech jobs, and it will encourage the whole educational system to move in that direction.

Right now, we have a problem in that funding research lasts for one or 2 years, but the research stream has to be funded for a longer period of time. You cannot just put a researcher on a project and say, "You are funded for 1 year, and then you are off." That does not do any good.

So by putting more of this money into medical research, you do create jobs. I do not know if anything has been done to look at that from an economic standpoint and the types of jobs that are created and what it does in terms of a pull on getting young people to take up this field of study in college or postgraduate study and get into research. I think that also has an economic impact, and I do not know if anything has been done to even look at that. I do not find this in any of the talk on health care reform.

Ms. TYSON. I think you are raising a very important point. I personally think we run a great danger in not just the biomedical area, but again, in all of our research support areas in this country. We need to make sure that we do not in a shortsighted way undermine what is a fundamental foundation of our long-term prosperity.

America's prosperity is based very much on its basic scientific breakthroughs, which then are adopted by the private sector, commercialized, and form whole industries. Our biotechnology industry is in no small measure the consequence of our support for basic science and research.

Senator HARKIN. Precisely, exactly. That is right.

Ms. TYSON. I certainly agree with that, and I do not see our health care reform proposal in any way at odds with your point of view.

Senator HARKIN. But it is silent. It is silent on medical research. It is not even a part of the health care reform, and it ought to be.

Ms. TYSON. Well, I will make sure that we talk about it as much as possible because I support the notion very much.

Senator HARKIN. Thank you.

Ms. TYSON. And the other thing I want to say about jobs—and I said this before you came in, and I just want to emphasize it again—it is incorrect to think that this health care reform will destroy jobs in the health care industry. On balance, it will initially create some additional jobs in the health care industry, then slow

the rate of growth down. Ultimately sometime in the next decade, in baseline terms, you are below where you would have been in baseline employment, but this is not the same as defense conversion. We are not downscaling our health care sector employment. We will change the composition, and we will slow down the rate of growth, but we will not downsize it.

I think that we should wed the benefits of basic science and research to our health care system even more effectively than we have done in the past, and I would be interested in working with you on this issue.

Senator HARKIN. Yes, I would like to work with you because I do not think anything has been done to look at the economic impact of medical research.

Thank you very much.

The CHAIRMAN. Senator Jeffords.

Senator JEFFORDS. Thank you.

I would like to get a little bit better understanding of economic impact. As you may remember, I am a supporter of the Clinton plan, so I hope you will take my questions as being somewhat friendly.

I introduced by own concept, called Medicore, which has quite a different financing system, but very similar to the Clinton plan in its other structure. Let me just ask you some basic questions.

I assume that the larger the payroll premiums which are required, the more of a negative economic effect that would have as far as jobs go.

Ms. TYSON. To the extent you allow the premium to rise without offsetting discounts, that is correct. The basic economics are that for any firm that is not currently providing insurance, or for any firm that is currently providing insurance, if you end up paying more as a percent of payroll, then that may in fact show up in terms of employment effects, a decline in employment.

I want to emphasize that there are other ways it may show up. It may show up in an increase in prices. It might show up in a decrease in wages. So that there is a lot of evidence—in fact, most economics tend to read the evidence that over long periods of time, the primary manifestation of an increase in health care spending by an employer is reduced rate of growth of wages for the employee. That is the primary—it is not the only way, but it is the primary way.

But yes, in general, what you have said is correct.

Senator JEFFORDS. Some of the payroll premiums now represent 12 or even 14 percent of payroll. If those were reduced to about half, would that have a positive economic impact?

Ms. TYSON. Yes, it would have a positive economic impact and could have an impact in any of the ways I have suggested. There are a number of ways that a positive effect could show up.

Now, of course, you then have to ask—there is one possible issue—we have to ask if we are going to reduce them that much, what mechanism are we going to substitute in place for paying for health care. But I assume you will tell me the answer to that.

Senator JEFFORDS. If you take no more money out of the private sector by your financing system than presently goes out of the pri-

vate sector for health care, would that be a rather nonevent as far as the overall economy of the private sector?

In other words, you spread it differently, so that the net amount that you take out of the private sector would end up being the same. Would that generally not have an adverse impact?

Ms. TYSON. Well, the problem with answering that question is, again let me emphasize, there are lots of ways firms can respond. So if you want to redistribute this total expense differently, some firms that are benefiting might decide to offer that in the form of wages. Some firms that are hurt might decide to take it in the form of higher prices or reduced employment.

One of the things I said before you came in was that the great difficulty in making precise estimates, even to answer a question like yours, is that we are dealing with a world, a starting point, where firms are not the same. They are not the same in terms of how much they are currently paying or whether they are currently paying. They are not the same in terms of the extent to which they are a high-wage or a low-wage firm, and a high-wage firm might respond differently from a low-wage firm.

So it is very hard. On average, if you did nothing but change the composition, on average, you should have an average effect. But I would not want to give you a precise answer precisely because the model——

Senator JEFFORDS. Oh, I am not asking for a precise on. On the other hand, certainly, if you take more money out, you are more likely to have a negative impact, then.

Ms. TYSON. If you take more money out, yes—I would say if you want to do it in likelihoods, I am willing to do it in likelihoods, yes.

Senator JEFFORDS. All right. Now, if you were able to get the deficit impact from health care under control in 2 years versus 8 years, would that be a positive impact upon the economy?

Ms. TYSON. I think anything we could do to reduce the deficit, particularly in a situation in which the reduction would come by improvements in the allocation of resources would be likely to improve the economy.

Senator JEFFORDS. Finally, we talk about a $45 billion saving in administrative costs. I presume if there is a lot of paperwork, that means there are a lot of people involved with that $45 billion. So in your job losses, did you consider what the impact would be of knocking $45 billion out of the paperwork stream?

Ms. TYSON. Yes, we have, actually. We have come up with our net figure for the health care sector as a whole; as a result of additional people going in for health care services or using more but different kinds of services—for example, more preventive or more long-term care—we anticipate that that on balance will create jobs, but that there will be some loss of employment in paperwork and in insurance. Then, when we net all of these out, we come up with an increase in employment in the health care sector overall of about 400,000 as the kind of immediate effect, and then over time, the rate of growth of health care sector employment would slow down.

So we did take into account the fact that a reduction in paperwork would mean a reduction in certain kinds of jobs, but that

would be balanced out, more than balanced out, by an increase in other kinds of health care sector jobs that are available.

Senator JEFFORDS. I was concerned by your response to Senator Kassebaum that you are happy—and that is probably not a good word—that we are creative an incentive for early retirement, and with the Social Security program we are going in the opposite direction, trying to encourage people to work longer because of longer life expectancy.

So I was wondering, do you really think it is a good idea to encourage people to retire early?

Ms. TYSON. I did not say that I was happy. I tried to make the case that when you think about the retiree issue, the most important place to begin is with the fact that if you have a system which guarantees universal access and which also community rates, so that the premium for a 55-year-old and the premium for a 25-year-old, except for firm size differences and regional differences, will be the same, that there is an incentive. That system is different in its incentive effects for early retirement than the system we currently have.

I do not see, without jeopardizing those two principles of universal access and community rating, what you do about it. There is the other issue of whether or not, if someone has a contract, and they go into early retirement, whether the Government should pick up the employer share of 80 percent. That is sort of the additional early retiree incentive. That does not cost every much. It is talked about a lot in the press, but it actually does not cost us very much.

But the big issue is not that issue. The big issue is simply what I said it is. We certainly do not want to have a system in which we say that if you are 55, and you have decided to retire early, you are not going to have access, or you are going to have a higher premium just because you decided to retire. That does not seem to be a possibility that we want to impose on the system.

So the truth is the system generates a different incentive. Now, incidentally, it creates a lot of good general incentives. An early retiree may decide to actually start a small business. And what you may think of as initially an early retirement decision may ultimately be a decision to try something new in life. And furthermore, the fact that universal access and community rating is exactly what you need to address job lock; it is exactly what you need to address welfare lock; it is exactly what you need to bring costs under control.

So any part of it, you can look at and say you do not particularly like the incentive effect here, but the net effect of this I think is a set of positive incentives.

Senator JEFFORDS. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Wofford.

Senator WOFFORD. Thank you, Mr. Chairman.

You touched on welfare lock, I think—I just read your testimony recently.

Ms. TYSON. Yes, I did.

Senator WOFFORD. That is a fairly significant factor in the economy, isn't it? My experience at labor and industry in Harrisburg found that many women with dependent children offered, chal-

lenged, encouraged to go into a very good job training program, with day care, with transportation assistance programs, asked, "Will I have health care benefits and my children have them if I take an entry-level job at the end of the training?" And too often, we were not able to say yes. It was a major disincentive we found.

What is the impact on the economy of the welfare lock?

Ms. TYSON. Our estimate is that based on existing studies of programs like the ones you are talking about is that about one out of 4 million families may currently be trapped exactly that way. If we could move one million families out of welfare simply by addressing their health insurance concerns—if we are going to have meaningful welfare reform in this country, then this has to be a building block for it.

So we view the welfare reform efforts that we are interested in pursuing with the Congress integrally connected to this medical issue, and we feel that it might solve as much as 25 percent of the problem by itself; that is, families wishing to leave now, but not being able to leave because of the fear of losing insurance—or the reality, not the fear, but the reality of losing insurance.

Senator WOFFORD. Dr. Tyson, would you talk a little about the effect of the present system—because we are comparing the new proposal not with perfection, but with the present system—in regard to the incentives now to employers not to hire full-time people, but to hire part-time people, and the degree to which the President's proposals will change those incentives?

Ms. TYSON. I want to emphasize to start with a general employment issue, that we have a situation in which we know that the largest number of jobs created in this country for a considerable period of time now have been created by the small sector of the economy, small size firms.

I want to start by emphasizing what I said in my oral statement. The system we have now is one in which the ultimate burden is heaviest on the small size firm. You have a system in which the cost of care for the uninsured is shifted onto the insured; the providers of Medicare and Medicaid often, then, inflate their private sector charges, so that goes on to the insured as well. And then you have a situation in which the large corporations in turn are able to use their market power to actually negotiate with the insurers to get a pretty good rate, so they pass off some of these costs by getting a better rate. So where do the costs ultimately fall? They fall the hardest on the small firms who have to pay 35 percent more or see their costs rising at 50 percent, twice as fast as the cost of the big firms.

So I think we have a system in which the job generators in the country, the small firms, have been bearing the big burden. I think that is very important to start with, because there is a concern about what this will do to small firms. I want to emphasize that the current system could not be worse for small firms, and they create jobs.

Now, the second thing about part-time versus full-time, I think the view here is that the way the part-time versus full-time rating of insurance would work, this would probably encourage firms to do more full-time employment, which many workers express in surveys that they would like to have a full-time job, but all they can

get is a part-time job. It is our view that this will encourage firms to actually go to the full-time choice rather than the part-time choice.

So I think it is an incentive to encourage small firms to employ more, and it is also an incentive to encourage all firms to go for full-time—it is a slight incentive to increase or go toward full-time employment.

Senator WOFFORD. The present system puts the incentives in favor of part-time workers and in favor of overtime work rather than hiring a new full-time worker.

Ms. TYSON. And in favor of large firms, right, yes.

Senator WOFFORD. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Coats.

Senator COATS. Thank you, Mr. Chairman.

I have two questions, but I want to start with a comment, and you do not have to respond to this unless you would like to. It seems that whenever we have a description of the Clinton administration health plan, or usually the first question to the witness is: If we do nothing, isn't it going to be worse?

But I do not know that that is a relevant question anymore, because I think everyone has agreed that the current system is flawed in a number of ways, it is inequitable in a number of ways, and there need to be changes.

But the choice that is presented to us by the administration is to do everything to cure a problem that we all acknowledge exists. So we are presented with a "do everything" plan, and that seems to be where we are running into problems, because we are talking about one-seventh of the economy, we are talking about extraordinary restructuring in the way we do business in this country, and we cannot seem to get a handle on, or we are not sure what all the assumptions are. We have talked about some of those this morning, that this might happen, that might happen, therefore that would affect cost, etc.

Don't you think that given the enormous implications for our economy if we do not do this right, that a less than "do everything" option might be something we ought to look at, at least in the short term, to see what kind of economic changes we can make within the system? I mean, is it valid to talk about a less than "do everything" proposal?

Ms. TYSON. I think I would need to know a little bit more about what a "less than' do everything'" proposal you had in mind.

Senator COATS. Well, there have been a number of plans introduced by a number of different people relative to saying, well, let us look at the medical liability, let us look at the inequities that exist between small business and large business, let us look at portability, let us look at pre-existing conditions, let us look at administrative reform. There is a whole layer of options that we can go through and probably gain a consensus on in Congress, a bipartisan consensus that says, yes, let us go forward with that and see what effect it has, rather than get into the questionable territory, as Senator Kassebaum said, of creating four new entitlements, when our experience with entitlements and our inability to control costs has been so wretched.

Ms. TYSON. Well, I think that what we have tried to do here is to look at what you would need to do to get the current system under control. And although the kinds of insurance reforms that you have suggested, and the malpractice reforms that you have suggested are important parts, they are really not enough; and they are not enough precisely because we have the following basic problem.

The only way to really get costs under control, the only way to get our system used efficiently, is to have universal access. A lot of the problems in our costs and a lot of the inefficiencies in our use are precisely because we have 37 million Americans who do not have insurance but who, in catastrophic or high-cost circumstances, receive services that the rest of us pay for.

Now, the only way to deal with that problem is universal access. It cannot be dealt with through portability of insurance, and it cannot be dealt with through pre-existing conditions, and it cannot be dealt with through malpractice reform.

So I think the "everything" nature of it is basically all tied to what we read to be the essential requirement of starting with universal access.

Senator COATS. I would like to talk a little bit about the early retirement entitlement. You talk about early retirees as those who decide to retire early. My experience is that most early retirees between 55 and 64 have been told by the organization that they work for that their services are no longer needed. We have a lot of very large firms in this country that are attempting to maintain or obtain more competitiveness in the global economy by downsizing. They admit that they were overemployed, and that therefore, to compete in the economy of the future, they are going to need to undertake and have undertaken some very, very substantial, forced early retirements.

My question is have we really estimated accurately what the impact of this is going to be. Clearly, it is an impact on the Social Security System, because those people will be drawing out of rather than paying into Social Security. But I am wondering really in terms of the cost, and I ask that question because initially, just a couple of weeks ago, Mrs. Clinton said it was going to cost $4.5 billion. Ira Magaziner then said, well, we think it is more like $6 billion. Other administrative officials have now said $10 billion.

We had a representative from the Ford Motor Company here last week who basically admitted that, gosh, if you are looking at downsizing, and the Government is going to pick up 80 percent of the health care costs of the people that you early retire, I am going to start at 55, in terms of the labor pool.

I had a CEO in my office who privately said, "We would be stupid not to—I mean, we have got to go through some very substantial layoffs and terminations in order to get competitive, and we would be crazy to lay off anybody except those 55 and over." He said, "That is just the reality of what it is, and that is why we endorse the plan. We are going to go out of business unless we do this."

So I am just wondering if we have accurately estimated what the cost is going to be to the economy and understood the reality of

how people make decisions when they make these decisions as to how to downsize their business.

Ms. TYSON. OK. Let me say that it is my understanding that the range that we have in mind is really in the $3 to $6 billion range.

Senator COATS. Well, then, why does Ira Magaziner say $6 billion?

Ms. TYSON. I said $3 to $6 billion.

Senator COATS. OK.

Ms. TYSON. It does include that number. We have also built into our subsidy or discount estimates a cushion to take account of the possibility that that effect would be larger, or that there might be in any 1 year more unemployed workers. So we do recognize that with all of these estimates, there is some uncertainty, and we——

Senator COATS. You recognize it is a great incentive for companies to do that.

Ms. TYSON. I recognize that there is an incentive. However, I wanted to emphasize that I thought that also, even if companies did not have that incentive, there is a new incentive for workers. So that basically, you have a situation where there is a voluntary incentive—workers may just want to do this, and the system we are designing may encourage them to do that relative to the system they are currently living in—and some employers may want to do that. That is exactly right.

As far as the costs to the economy are concerned, again let me make a distinction here between the incentive we are creating through universal access and community rating—which I believe is part of the overall health care package we are proposing. Then there is the incentive for the early retiree benefit which would be available to large companies with these contractual relations. That is the $3 to $6 billion. Then there is the issue of what are the effects of that on the economy.

Well, it seems to me that there are arguments that could be made of beneficial effects to the economy. We want to encourage companies to engage in the competitive restructuring that they need to encourage and to meet international competition. American companies have, I think justifiably, said that they operate in a system where they do not have the same degree of flexibility on this issue because their international competitors have systems in which retirees are supported by other kinds of funding mechanisms.

So the costs to the economy, I think you have to take into account that there are some benefits to the economy from this as well, and presumably, companies that are restructuring are doing it for the reason of trying to gain market share over their international rivals, and that ultimately the competitiveness of the U.S. economy depends upon a competitive U.S. industry. So this may in fact be a benefit to the U.S. economy.

And I do not think the price tag, the price tag of just the special retiree benefit, is very large, particularly given that, as I said, the real issue here is the incentive for retirement in general.

Senator COATS. Have you run an economic model of this? Is there an economic model to give us some——

Ms. TYSON. No, although I would say the following. You hear about the employment effects of the health care reform proposal,

and I said before you came in that our estimates are in the range of plus or minus half a percent of the employment level. Those numbers, anybody's numbers like that, include voluntary retirees. They include people who just decide to leave the labor force. That is an employment effect.

We have 117 million people employed right now. In a different health care system, some people may choose to leave employment. This is not just a person age 55; this may be a person age 45. And we have changed the incentives by the health care system.

I think that basically, the benefits of universal access and the benefits of community rating are such that we want to maintain these things. but the employment numbers do include those effects.

Senator COATS. My time is running out, and I will just ask one last question. In response to Senator Jeffords' question—I guess I want to follow up on that question—about no net cost to the private sector, isn't it true, though, that under the plan, we are creating a situation whereby those employment entities and manufacturing firms that have basically not been very progressive in terms of looking at the impact of health care costs on their total net business cost—Ford, for instance, paying 20 percent of payroll for health care costs, essentially because they bargained themselves into a position where they provided first dollar coverage for everything—for those firms, there is going to be a huge windfall, because their 20 percent is going to drop to 7.9 percent. And those are the firms, by the way, that are not competitive as a result and are laying people off. So the cost is going to be shifted from those firms to firms that have been progressive, are competitive, have negotiated much more sensible health care cost plans with their employees—we had a dramatically example of that last week, where we heard from Ford and General Mills, and General Mills is paying 4.7 percent—they are going to be paying the windfall.

In other words, the people who have seen this coming, the people who have addressed the question—and they are the ones who are more competitive and therefore growing and therefore adding jobs—they are going to have a cost shift from those who have not really done the job. How is this going to have an overall net plus impact on the economy of the country?

Ms. TYSON. I think the numbers suggest that actually the employers who are currently providing will by and large benefit. So that if you phased this all in in 1994, for example, then the employer spending for the 70 million workers who have insurance would fall. It would fall. So although there might be some firms that would get a better deal than other firms, they would all benefit.

I think it is incorrect to say that somehow, Ford is going to pass this off onto another insured firm. The workers who are insured——

Senator COATS. Well, they have admitted they are going to get a $1.2 billion windfall, and it has got to come from somewhere.

Ms. TYSON. We are going to reduce business spending, and if we reduced it overnight in 1994, the employers who provide insurance would benefit, and there are some firms that would benefit more than others. But all of those firms would benefit.

So what I was saying is I do not think it is appropriate to think that just because Ford may benefit more than another company that is insuring does not mean that the other company that is insuring is losing; it is also benefiting.

Senator COATS. But my point is what is the equity in providing a bailout for the firms that really did not do the job and imposing extra costs on the firms that did do the job?

Ms. TYSON. I am disagreeing with you because I do not think we are imposing extra costs on the firms that did do the job.

Senator COATS. Well, General Mills' rate is going to go from 4.7 to 7.9.

The CHAIRMAN. No, no, it does not. It stays just where it is.

Ms. TYSON. That is right. First of all, General Mills almost certainly can decide what it wants to do itself; it is a big enough firm that it can be——

Senator COATS. Well, that was not the testimony of the General Mills representative. He said that inevitably, with the alliances and the way it is set up, you will have to move into the system.

Ms. TYSON. But they do not need to be in the alliance.

Senator COATS. They said they are going to be forced into the alliance, that under the plan there is just no way not being in there.

Ms. TYSON. Well, I think that a lot of misinformation about this plan is out there. I mean, small firms who thought they were going to be hurt by it, having read it, now conclude that they are going to be helped by it.

I think maybe we should make sure that General Mills understands that they are in a situation where presumably they can opt out of the alliance altogether. Their desire to go into the alliance would depend upon whether they think they can get a better deal in the alliance by staying self-insured. So I do not think that example rally works.

The issue, I would say, if you want to think about the compositional change, is between firms who are currently insuring and firms that are not currently insuring. Firms that are not currently insuring will have to pay more. Some of those firms, however, a large number of them in a number of surveys suggest they actually would like to provide insurance for their employees, but they cannot under the current system.

So if you just looked at the numbers, you might say that right now, they are paying zero percent of their payroll, and 3 or 4 years from now when they are phased in, they are paying 3.5 percent, and they are worse off. If you ask them, they might say, "No. We are better off. We wanted to provide insurance all along, and we could not, but now we can."

So I do not think the payroll percentages can tell you all about what is going on from the point of view of the compositional effects.

The CHAIRMAN. Senator Gregg.

Senator GREGG. Well, that is an unusual economic analysis to say the reason you can defend this position from an economic policy standpoint is that you have concluded that firms that are going to be told by the Federal Government that they must undertaken an additional cost and are hit with a payroll tax of 3.5 percent to 7.9 percent, that they really wanted to do that all along, and that the

reason they have not done it is because the Federal Government has not told them to do it. That is an interesting economic analysis.

But independent of that, please explain to me this community rating concept. If I do not smoke, and you smoke, and I know statistically that because you smoke, your life expectancy is less, and your cost of health care is significantly higher, why should I have to pay a higher premium for the smoker?

Ms. TYSON. We are trying to deal with getting a system of insurance which makes sense. The system we currently have——

Senator GREGG. That is what we are trying to deal with?

Ms. TYSON. Right. That is what we are trying to do. We are trying to find a system that makes sense. The system we currently have is a system which allows insurers to basically try to get rid of the insurance risk, to try to find only those people who do not need insurance and then provide insurance for them. So that all of the people who need insurance, because they have pre-existing conditions, because they have a high-risk job, because they work in an industry with high risk of illness, they cannot get insurance, or they can only get insurance at exorbitant rates. Many of them therefore do not have insurance.

Now, does this work to the benefit of me, the privately insured person? No, it does not. It does not work to my benefit because when I pay my insurance, I am paying for their insurance. If they cannot get insurance because the current industry will not give it to them, then I am paying for their insurance. So community rating is an attempt to pool risk. That is what insurance is all about. Insurance is about pooling risk so that we all share the risk, so that no single one of us bears an intolerable amount of risk, which we cannot afford. And our system has let us down.

Senator GREGG. Well, that might be applicable in pre-existing conditions, and in fact all the proposals that have been put forth address the pre-existing issue. But it is your proposal that uniquely says that a person or a group of people who are committed to health because they do not smoke, because they do not drink, because they undertake physical exercise, that those people are going to be penalized—penalized—because they are going to be rated the same way as the people in the community who take no concern at all for their health because they smoke and they drink and they just do not undertake healthy lifestyles.

Now, I do not understand if the goal is, as you said—and I agree that that is the goal—the goal is to improve health care and to get a better system, why you would structure a system that inherently discriminates against people who attempt to improve their life styles through healthy life styles and encourages nonhealthy life styles that are general life styles, such as smoking and drinking.

That may be community rating in your concept, and that is community rating generally, but I do not understand why it makes sense. And I am taking off the table the issue of the pre-existing condition people, because they are already going to be addressed by everyone. I am talking about why you have a community rating system that penalizes people who have a healthy lifestyle and discriminates against them to the advantage of the people who do not.

Ms. TYSON. Again, you have to start with where we are. I am a healthy person, and I do not smoke or drink—I drink wine at din-

ner, but I do not smoke at all, and I never have—and I would say that I am already penalized. You have this notion that somehow we have a perfect system where I am not influenced by the smoker or the drinker; if course, I am, and I am influenced much more profoundly than I would be under a community rating system, because that person will go to the emergency room when he has a cough, and he will get an x-ray of his lungs, and it is in my insurance premium. If they are community rated, and they have insurance, and they have preventive care, and that preventive care includes information about the dangers of cigarette smoking, and it includes information about how to change your life style, I may very well be much better off living with the drinker or the smoker than I am now.

So I think your starting point is wrong.

Senator GREGG. No. Your starting point is wrong. You are assuming that people who live a healthy life style should have to pay a higher premium.

Ms. TYSON. I am saying the people who live a healthy life style already are paying a higher premium because of people who are not currently insured.

Senator GREGG. They are going to be paying a much higher premium than if they are in an insurance policy where you have the opportunity to have that policy adjusted by your life style.

Now, I do not understand why you are putting forward a proposal which does not encourage people not to smoke through the usual incentive process that we have in a capitalist system, called "paying for it." If you want to smoke, you should pay more for your premium. If you drink heavily, you should pay more for your premium.

Ms. TYSON. Can I suggest that we have looked at the issues of families and who wins under the current proposal, and these are the facts. Two-thirds of American families will be better off in terms of seeing a decline in their health insurance premiums—two-thirds of American families.

Twenty percent will pay more initially, but for better coverage; they already have coverage, but they are paying more. That leaves the young, single Americans, or basically young workers, most of them single, some with families, who will pay more and not for more.

So if you are talking to talk about the community rating issue, the issue really is one that as a young, healthy person, your incentives to get insurance are somewhat diluted. You tend to get less insurance than what our package is proposing, and we are going to require you to get more.

On the other hand, you have a whole life—and presumably it is going to be a longer life because of our health insurance scheme—so over time as an individual going through life, you will end up paying substantially less because as you get older, under the current system your premiums would go up and up and up; under our system, you pay more when you are young and less when you are old, and over your lifetime, which is going to be longer, you pay less.

So I agree that there are some people here who will pay more. It is primarily an age issue at this point, and I think that that is what the facts of the proposal turn out to be.

Senator GREGG. Well, I really do not think that is responsive to the issue of the smoker and the nonsmoker, because whether you are in a family or whether you are single, the smoker/nonsmoker issue cuts across all those demographic groups.

Ms. TYSON. Is it that you would want just that exclusion? I mean, would you want to have a community rating but for smoking and drinking?

Senator GREGG. I think there are a number of conditions which people put upon themselves which cause their health to be less, which cause their health care costs to be higher, which traditionally, the marketplace has acknowledged as being self-inflicted—smoking and alcohol being the primary ones, but drug use would be right up there with them. And to take a community rating system and say that those people who do that to themselves, those people who undertake that health risk themselves, are going to become the burden of everyone else who does not undertake that health risk, is not creating an incentive for better health care; it is creating an incentive for worse health care, and it undermines the cost of health care and it undermines the confidence people have in what the theory is behind the health care proposal.

I guess my time is up, Mr. Chairman.

The CHAIRMAN. Of course, I think HCFA points out that actually, the nonsmoker costs the health care system more because they live longer. [Laughter.]

Senator GREGG. That is an interesting analysis, but I suspect HCFA probably did come up with that conclusion, Mr. Chairman.

Ms. TYSON. That is a good one.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman.

This is both a delightful and interesting discussion, and it just proves the value of keeping this whole reform process going as long as we possibly can.

I was hoping that Dr. Tyson's response to the question from my colleague would be, "Why do you own fire insurance, or why do you own automobile insurance?" I am assuming that you are probably a very careful driver, Judd, and have not had an accident in a long time. I am sure that you live in a home that is building code approved, and you take steps to make sure that that home is——

Senator GREGG. But of course, if my neighbor has had six accidents, his policy price goes up.

Senator DURENBERGER. Well, that is a questionable way in which some insurance companies, as she points out, try to avoid risk. There is the value of insurance as a way of spreading risks, and the cost of that neighbor and everybody else having insurance makes a big difference.

I think the first question is do we insure for catastrophic coverage, like in fire or the loss of a life in an automobile accident, or are we insuring for health maintenance. And it is pretty clear that Americans have gotten used to insuring themselves for health maintenance, for all the very ordinary things that go on in our lives, rather than for the catastrophic. And it is pretty clear that

one of the debates we are going to engage in is, as to the basic benefit package, are we going to do a catastrophic, as some of our colleagues have proposed, with basic preventive care, or are we going to try to do a more comprehensive coverage.

But to get into the point of the hearing, the point that my colleague raises relative to life style impact does not have to be dealt with only in the price of the premium. It can also be dealt with in the value to the employed person of the employer's contribution. And I must say that one of the things that bothers me greatly about the administration's proposal is that it turns the employers in this country into check-writing agencies, as we have done with so many other good things that employers have suggested to us. That in effect all of the things that General Mills has already done to try to use their contribution to the employees' premium as a way to encourage healthy life styles, not overutilize the system, get into relationships with providers in the community, are discouraged by this kind of approach.

What one of the witnesses after you will say is that, "In its efforts to hold down the explicit budgetary costs of health reform, the administration has developed a plan that is the worst of both worlds. It is too regressive to be equitable, but too distorted to be efficient. The fundamental overall problem with the administration's strategy is that it proposes to use the employment relationship as the basis for mandated coverage. The only reasons for doing so are force of habit or historical accident and the attractiveness of financing a public program with an off-budget tax generated to confuse the electorate."

And let me take that just one step farther, if I might, and just ask you this. Would you please try to justify for us Government-imposed limits on private spending in this country? Some people say the biggest problem we have is $903 billion being spent. Tell me why that is a bigger problem than the problems of market failure in this whole system that end up giving us those kinds, at least in part, of costs—restricted entry into the system which Government imposes through licensure and a variety of things like that; price distortions, which are all over the place, which are reinforced by Medicare and Medicaid and a whole variety of reimbursement systems; poor information, which Government does not do anything about, and that is one thing where Government could—it could force more information into the system; the insurance industry—for political reasons, we have decided that up until now, we are not going to take on the insurance industry, so we end up having a situation in which all of these people are out there competing to avoid risks, as you appropriately pointed out.

So I hope my question is clear. If you would agree that market failure in some of these respects is really the problem, then why is it that so much of what the administration is recommending appears to be aimed at containing the private spending in ways that a lot of us would suggest, and other witnesses before this committee have suggested, might be getting in the way of restoring markets?

Ms. TYSON. There are actually a number of ideas which came in your question. First, let me talk a little bit about the limits on private spending, which is the critical part of your question.

I think the view is, as you well know, that we have tried to develop health care reform which is very much based on the best practices of the private system. That is, we are trying to model, based on what we have learned from employers who have done a good job at encouraging health maintenance organizations, at figuring out efficient care delivery mechanisms, and building on State experience as well, for both State and private sector experience.

So our system really is one of managed competition. The limits on private spending are meant to be a backup or an emergency break or a failsafe mechanism. So I think the debate really should appropriately be about what do you think the odds are that these will bind. That is really the issue. If you think that there is enough inefficiency in the system, that by the year 2000, we can easily save 10 percent off projected spending simply be encouraging providers to form more networks and allowing consumers to have greater choice—after all, we have a situation now where only 30 percent of the employees of companies of 500 or smaller have any choice at all. There is no choice. That is a market failure. We do not have market competition in the choice of providers, and we do not have an incentive for providers to network. So we are going to put these incentives in, and we believe we can get that 10 percent saving by the year 2000, without the private sector caps binding. But they are there. So the debate between us really is a debate about what is the probability that they are going to hit. And our reading of the evidence is that the probability is not high, but we absolutely have to have it, and the reason we absolutely have to have it is because whatever happens to this health care reform package, it seems to me it is very likely that we are going to have some form of restraint on the growth of our public sector programs, Medicare and Medicaid, where the Federal Government is now spending 40 percent of our national health care budget primarily through those two programs.

If we try to rationalize and control those programs and do nothing to the private sector, we know what the consequences will be. The consequences will be——

Senator DURENBERGER. But pardon me—you are not recommending rationalizing any of those programs. I mean, the efforts that some of us have made to urge you to reform Medicare in some very substantial way so that it can be bought in the private sector from accountable health plans have been rejected as political.

Ms. TYSON. Well, we are going to make a series of very specific proposals on what our Medicare proposal is, what the cuts will be, and I think at that point we should have that discussion, because it is our intention to reform those systems and to make them work more efficiently. But if we try to work just on that part of the budget and not on the private sector budget, the result will be a ballooning out of the private sector budget.

So I think we absolutely have to have these limits in there, but our view is that the work is really going to be done by changing incentives and not by the budget caps. That is the first part of my answer.

A number of other things you mentioned, I think we are trying to do. One of the main responsibilities of the regional alliances would be to improve information to consumers. I have to profess a

great deal of ignorance about health insurance, the plans that are available to me, and someone has to sit down and tell me what they are. And as I said, lots of people have no choice at all. What the regional alliance guarantees is that no matter how small you are, if you are an individual, self-employed person, you have a choice between three plans; you will have full information about those plans; you will have a report card on those plans, and you can make a wise choice. So information is a very important part of what we want to do.

We certainly want to reform the insurance industry along the lines that you have proposed. And you talked about restricted entry. I again want to emphasize that the reality that we are starting with is that most people do not have a choice anyway, so this will expand choice and expand entry opportunities for many individuals.

Senator DURENBERGER. I am just talking about restricted entry of people who want to practice better medicine and/or get to a more appropriate end are restricted from doing that by the current system. There really is not an opportunity in the current system to reward good behavior.

Ms. TYSON. You mean with the current proposal. But ultimately, you have a system in which the better providers who figure out a better way to do this with capitation will be more profitable, they will attract more consumers because they will have a better report card, and they will be the ones who grow. That is the managed competition aspect of this.

The providers who do not do a good job will not be able to make any money in the current system because of capitation, and furthermore, I assume their report cards would show things like long waiting times, and consumers would move to the other plans. So this should help the good providers.

Senator DURENBERGER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Dr. Tyson.

Two final questions. Just yesterday, we were down in the southeastern part of Massachusetts, where we have the highest unemployment, and we talked with some of the small business people, who were pretty evenly divided, actually, in terms of the mandate issue. Have you figured out, even with the 3.5 percent, what that impact would be in terms of being sufficiently troublesome to be the straw that breaks the camel's back in terms of the country generally?

Ms. TYSON. As I pointed out in my written testimony, this means essentially, given the caps for small, low-wage firms, you are talking about what would be equivalent to an increase of 15 cents to 35 cents per hour in the minimum wage. That is a figure which recent studies have demonstrated or clearly suggested is likely to have a very small impact on the employment prospects of low-wage workers.

Some of the low-wage workers may see a slower rate of growth in their wages over time, but the notion that firms will not be able to absorb that amount of an increase is really a notion that is called into question by the most recent research. I think 15 cents to 35 cents an hour still leaves us below minimum wage levels that

we realized in the 1980's, with lower unemployment rates than we have right now.

The CHAIRMAN. Finally, you have had a chance to review the next panel's testimony. Would you be good enough in a summary way to just give us a brief comment on those?

Ms. TYSON. Sure. First, I already mentioned Dr. Lewin, who will talk about the Hawaii experience. There are lots of models you can look at about what are the effects of this or that change, but we actually have a real experience to look at in the Hawaii experience, and that experience suggests that in fact the employment concerns associated with this kind of health care funding mechanism have not proven to be real issues in the State of Hawaii. So that is the first point.

In the paper by Dr. Klerman, his conclusions are by and large absolutely consistent with ours. As I said, our basic conclusion is the net effect on employment; if that is what you want to look at, if that is your metric or standard, we can give you runs that generate plus or minus one-half of one percent of the employment level, and that is exactly where Dr. Klerman is coming out.

He emphasizes, as we do, that the employment effects are small. He also acknowledges that his results so far do not take into account some of the beneficial effects of the plan that we have tried to take into account. So we generate some positive numbers in our runs because we have taken into account some of the beneficial effects of the plan in terms of bringing down business spending over time.

So in general it is consistent with our reading of the evidence.

Dr. Pauly's testimony, we are confused by, because our reading of his, I think self-avowedly back-of-the-envelope calculations, suggest that he is using a very high what economists would call elasticity, or what we might call the sensitivity of employment to a change in labor costs. In fact, doing what we know about our plan and the discounts and all the rest, doing what we know about our plan, we conclude that he is using an elasticity that may be 10 to 20 times as large as the standard elasticity in the labor economics literature.

So even if you wanted to do a simple employment effect, we are confused by where he gets the numbers he gets, because our reading of our own plan is that this elasticity or sensitivity measure is really much too large.

It is also important to note, and I said this in a couple of my responses, that he talks about a decline in health care employment. It is important to understand that this is a slowdown in the rate of growth of health care employment relative to where the baseline would otherwise bring us. The net effect at the beginning is to increase health care employment and then to slow its rate down.

Health care employment does not fall absolutely in our world. It does not fall; it slows down.

And finally, this study, like the rest of the studies, does not take into account the fact that a lot of firms are not just winners in the year 2000, but they are winners once they get into the alliance. Their costs fall right at the beginning, and those firms can do a lot of possible things with their benefits. Anything they do with the benefit of the health care system benefits the economy. We are not

sure exactly what they will do, but it is beneficial to the economy. And that is not in this paper.

So those would be my quick reactions from a quick reading.

The CHAIRMAN. Senator Jeffords.

Senator JEFFORDS. Just a quick follow-up. Being a member of the 55 to 65 group—and I am sure you are not—I would just pass a little information on. It is the most discouraged group of people in the world when they get laid off. If you are in your 50's or 60's, and you are not an executive who has the capital to open a small business, it is a very, very severe and discouraging thing.

I would say that I hoped the result would be the opposite, that the tendency will be not to create early retirees, because there will not be the risk of higher health care costs for that group, and therefore there will not be the attempt to risk-screen at the employment level.

Ms. TYSON. I absolutely agree with you, and furthermore, we can accept that over time what this does is it allows people in that age group a choice if they would like to retire early, but it does in fact do exactly what you said. It brings down the costs of keeping the employee from the point of view of the employer. So I think that that should actually work as a benefit to that age group.

Finally, let me say that the issue that you have raised of whether or not this will cause firms to downscale even more than they would have otherwise is something we are looking at, and we are looking at ways to try to phase this in or have the firms pay for more of that benefit if they want to exercise it.

So we are sensitive to this issue.

Senator JEFFORDS. From an economist's perspective, the biggest concern right now seems to be health care, but right on the horizon is pensions, and anything that we do that gets rid of people before they are vested, or any tendency to put people out before they have a viable livelihood in senior years is going to be of very deep concern to all of us.

One final, quick question. Did you add up the amount of all the accrued liabilities that were added under the new accounting processes for the corporations that had to accrue their future health care benefits?

Ms. TYSON. I do not think we have added all that.

Senator JEFFORDS. I have a feeling if Ford was $1.2 billion, and I think IBM was over $2 billion, that you are going to a get a figure that is an awful lot bigger than $3 to $6 billion if you add those up.

Thank you.

Senator DURENBERGER. Mr. Chairman.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. May I put in writing the question that I asked Ms. Tyson, and maybe I can clean it up a little and make it more precise, because I think at least in part, the commitment to go with an employer-based system and the way in which the plan currently recommends doing it causes enough concern for enough people so that it would be at least helpful to me and probably to some of my colleagues, especially here, to deal more fully with that.

So if I may, I would like to do that.

Second, you might clarify for us the recommendations relative to health alliances. I just walked in when we were doing General Mills, and I was not here Friday, but my impression is that the administration has a system in which they try to get as many employers as possible into the regional health alliances, and that the 5,000 employee cut-off really would not be by company; it would be by community, since competition and all the rest takes place at a community level. So if General Mills has fewer than 5,000 people in Minneapolis, then General Mills employees would be in a regional health alliances, and they would not have an option.

Is that a correct interpretation of the recommendation?

Ms. TYSON. I think that is not correct. Basically, the whole idea of the firm size exclusion was that we have to deal with the reality that for big employers who cross many State lines, we cannot impose on them the administrative costs of having employees in different regions and different regional alliances.

So my understanding is we have the 5,000 employee limit precisely so you can remain self-insured and out of the regional alliance—all of your employees, regardless of where they are located.

Senator DURENBERGER. We might check that out.

The CHAIRMAN. If the Senator would yield, that is correct. It does not make the problem any easier. For instance, Textron, a company in Massachusetts, is in 40 different States. So this does not make the problem any easier. Obviously, in some areas, there is not going to be any competition. I know that this has been a reality which they have attempted to address in the program, and we will have a chance to take a look at the language later on.

Ms. TYSON. The real reason for doing this was precisely to deal with firms who are already dealing in 40 different places, they have already got arrangements for this. To try to require them to go into several different regional alliances would really undermine their own effectiveness.

I will be happy to write an answer to the question, and will work on one. On the general issue, the quote you read, you could write the same explanation with different words. The reality is that we are not starting from square one, and we are trying to reform a system which is one in which even two-thirds of employees in firms with less than 100 employees are currently covered by their firms. That is the reality. It seems to me that the way society has moved forward is in general by making adjustments to where they start, not by starting over.

So if we had a different starting place, we might not work with an employer-based system. But the fraction of Americans who are covered by their employers is simply the overwhelming majority, so that seems to be the sensible place to start.

The CHAIRMAN. OK. Just listening to Senator Durenberger, I recently purchased a car, and it was very interesting as I watched the various advertisements. The two things that are going for them are the antilock brakes and the twin airbags. That is setting the standard in terms of what people are buying today. It is extraordinary how the automobile companies are adjusting to that kind of demand. And of course, we really do not have the competition in health care existing even with the major automotive companies,

which obviously makes all of this much more complex and difficult in how we structure competition the best that we can.

Thank you very much.

We will leave the record open for additional questions, and I am sure we will be talking with you again, soon. We appreciate it very much.

Ms. TYSON. Thank you for the opportunity, Senator.

The CHAIRMAN. Our panel includes three experts with differing viewpoints who will comment on the economic implications of the President's plan.

John Lewin brings the unique perspective of the State of Hawaii, the only State in the Union that has implemented an employer mandate. Dr. Lewin has some fascinating new findings to report on what has actually happened to small businesses and employment in Hawaii as a result of the mandate.

Dr. Mark Pauly is chairman of the Health Care Systems Department at the University of Pennsylvania. He is a health economist and the author of a plan to provide universal insurance coverage through an individual mandate. He is a critic of programs that require employers to provide or contribute to coverage.

And Dr. Jacob Klerman is a labor economist at the Rand Corporation who has written extensively on the employment impacts of various proposals to extend universal health insurance coverage by requiring employers to provide coverage and contribute to its cost.

We will start with Dr. Lewin.

STATEMENTS OF DR. JOHN C. LEWIN, DIRECTOR, HAWAII STATE DEPARTMENT OF HEALTH, HONOLULU, HA; MARK PAULY, CHAIRMAN, HEALTH CARE SYSTEMS DEPARTMENT, THE WHARTON SCHOOL, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PA; AND JACOB A. KLERMAN, LABOR ECONOMIST, THE RAND CORPORATION, SANTA MONICA, CA

Dr. LEWIN. Thank you very much, Mr. Chairman and Senators. It really is a pleasure to be here. I bring you greetings from Governor Waihee and the people of Hawaii.

Hawaii has been in the spotlight of late in terms of health care reform issues, simply because so much of what is being discussed nationally has already occurred in Hawaii. I have been accused at times of being a salesperson for Hawaii's system, and I want to start off by offering a disclaimer to that.

I think Hawaii's successes stand on their own, and in fact, we are the most expensive society in America today as far as States go in terms of real estate average costs and in terms of consumer products, which are nearly 40 percent above the national average at the present time.

Hawaii's accomplishments have been difficult to come by and have required a lot of courage and action on the part of many people who have preceded me. I have had the privilege of being the director of health in the State for the last 7 years, and we have taken some major steps in that time as well to close the gaps. But we will be talking about what really has been the foundation of our successes, namely, the employer mandate, which dates back to 1974.

We have a system in which we have an employer mandate that covers about 83 percent of our population, the employees and their dependents. We also obviously have Medicare and Medicaid. Our Medicaid system in Hawaii is generous, it is very broad, and it covers a wide array of benefits and more people than most State programs have been able to do.

We have added a mandate for substance abuse and mental health insurance coverage as kind of a wraparound to the Prepaid Health Care Act, which is now available to more than 92 percent of our population, and also is available to Medicaid in a different form, so that we have nearly universal mental health and substance abuse benefits, although they are limited compared to what I would like to see them be in the future.

We have a very extensive public health system, and we have invested a lot there compared to other States. And we have a certificate of need process that we have really used very effectively and extensively compared to other States, which has contributed to less overcapacity of hospital beds, and the technologies and better utilization of those.

These all contribute, but the success of Hawaii is that we are at 98 percent access to health insurance coverage; the remaining 2 percent of people are going to be extremely difficult to bring into the system, because they are often people who are homeless or mentally ill, or who simply do not lend themselves to insurance kinds of systems, and it will be extremely difficult in any society to bring these people in, but we are committed to all of them. The commitment is to 100 percent, and everyone in Hawaii has some access to an insurance program if they make less than 300 percent of Federal poverty; if they make more than that, then they can afford to buy a program. Everyone in the work force is mandated to buy a program.

The outcomes in Hawaii are also very impressive. We have the lowest rate of infant mortality in the Nation this year. We have the lowest morbidity and mortality from heart disease, global cancer, emphysema. Outcomes look really, really good in terms of medical care costs and in terms of just plain medical outcomes.

Costs of care. As a percent of gross State product, our costs are comparable to Canada, Germany, Sweden, the Netherlands, and are far less than the rest of the United States and less than 9 percent of our gross State product.

In terms of consumer satisfaction, Hawaii was surveyed with Harris polls along with all the other 49 States compared to Canada, and we come out with the highest degree of consumer satisfaction of all 50 States, at 74 percent very happy with the system compared to 40 percent U.S. at-large, 18 percent unhappy with the system compared to 57 percent U.S. at-large.

In terms of medical system costs and the kind of system, we are the high-tech, glitzy American health care system, where physicians make a lot of money, where hospitals are high-tech and certainly very expensive.

But given all of that, and given the accomplishments, I want to point out that we fully support national health care reform. We need national health care reform. We need it to bring the dysfunctional aspects of our system, namely Medicare and Medicaid, into

the efficiency of the rest of the system. We need it to work in no-fault auto insurance, in workers' compensation. We need the data and outcomes commitment that has been mentioned in the Clinton strategy, and we certainly need some kind of tax system that offers some more incentives for people to purchase more carefully and more efficiently.

So we are very excited about the Clinton strategy as terrific progress and leadership and a bold step forward, and we would like to see national health care reform.

The background for the employer mandate for Hawaii is that the critics always talk nationally about how we are going to see an enormous loss of jobs, small business failures, and so forth. What we can tell you from practical experience is that we have had to face this, and it was not just back in 1974, Senators. One thousand new businesses form each year in Hawaii, and they all have to come in and face this when they start. A new McDonald's franchise, a new dry cleaning establishment, they have to face it today—in 1993, in 1992, and in 1991. We are familiar with the reality of it.

We think the critics who do not understand what has happened in Hawaii fail to see that we have a level playing field, that we have standard insurance benefits, we have insurance market reform, our employer mandate offers every small business the same low rate that the big businesses have in the State. The community rating means that if they hire somebody with HIV disease or AIDS into their business tomorrow, in a "mom and pop" store, that their insurance rates do not go up and that the individual's rates are the same as anybody else's in the State. Trying to understand how it might be in that environments for small businesses is difficult, but in fact in our State, the small businesses that were not providing coverage back in 1974, yes, they had to add an increased cost of goods and services, but in fact the public was willing to absorb that increase. Hamburgers went up 25 cents, dry cleaning a shirt went up a dime; people paid the difference. And in fact, those businesses made it without an enormous subsidy, and they have been insuring for 20 years.

We eliminated a lot of cost-shifting, and we believe we created new jobs by virtue of the fact that the businesses that previously were paying exorbitantly high rates when we did not have community rating have lower insurance costs now. In fact, all of the small businesses in Hawaii have lower insurance costs than could be purchased anywhere else in America.

The Prepaid Health Care Act is our employer mandate, and it took a number of years of study to bring it in. I think people know that we are a Democrat State, but this is a bipartisan issue, and our employer mandate looks very much like what Richard Nixon was proposing in 1972 through 1974.

The law itself as applied needs to be clarified a little bit. In the original law, dependents were optional; although the employee could say that my dependents will be covered, and the employer would have to include them, the dependent would have to also agree to take on part of the share of the cost for that dependent coverage. In fact, dependent coverage is universal in Hawaii. All

dependents have taken them on, and it has become a universal process.

The benefit package looks very similar in reality in Hawaii to what the Clintons have proposed in their benefit package. Although originally, mental health and substance abuse were not in the package, dental, drug, and eye coverage were not in the package, we have mandated mental health and substance abuse as a kind of wraparound insurance mandate, and dental, eye, and drug benefits were added as a community-rated supplement that 85 percent of the public has voluntarily purchased. So in essence, Hawaii functions like it has the benefit package today.

Originally, insurance reform was not written in as mandated community rating, but in fact community rating became the norm because the law says that all in the work force and their dependents must be accepted by any insurer without regard to pre-existing condition. And by virtue of that, all of the sick and the chronically ill became part of the program either by virtue of being employees or by being dependents of employees. Just about everyone has somebody working full-time in their family. So the insurance companies took that burden on, and they transformed themselves, frankly, from insurance companies to health care companies because they had to manage chronic disease; they had the burden, and they had to deal with it. And that puts us in a very different world. That is how managed competition has come about in Hawaii. Hopefully in the questions, we can go into that a little more.

I have included in my testimony some charts to show you something about the effects of the mandate on the economy—the major industries, what they are in the State, the relationship to gross State product. The gross State product chart, by the way, is in 1982 dollars. Our gross State product this year is over $30 billion. But I tried to give you an inflation-protected relationship to gross State dollars there.

I show you that we are a small business State, the 98 percent of the 25,000 businesses in Hawaii have less than 100 employees, and in fact 90 percent have less than 25 employees; that new business growth has not been impeded. From 1974 until now, we see an increased number of new businesses created each year as compared to U.S. averages.

You see a decreased number of business failures compared to U.S. averages. You see no effect on unemployment. Where you see unemployment going up and down on our chart, it relates directly to the U.S. economy, nothing to do with health insurance costs in Hawaii.

And in fact I think most important is the last addition. Dun and Bradstreet published in the Wall Street Journal a study by David Birch, an economist, that shows that Hawaii is the place which is most favorable to new entrepreneurial ventures and in fact over the last 5 year has, more than anyplace in American, new businesses of under five employees that are growing and thriving. Even after Hurricane Iniki, even during this 2-year slump in tourism, Hawaii's small businesses are doing really quite well.

We need to point out that small businesses have an ideological issue about Government mandates. They do not like Government mandates. But in essence, we have had a number of important fac-

tors to demonstrate. From 1982 to 1984, Hawaii's law was declared void by the Federal appellate courts when challenged by Standard Oil on the basis of ERISA. It had been in place for 8 years. For 2 years, small businesses could opt out until we went to Congress and got our ERISA exemption. We know of no business that did.

When you ask NFIB why small businesses did not opt out during those 2 years, they give you 2 reasons. One, employers had become accustomed to providing health insurance; it was a kind of way of doing business in Hawaii. And two, that employers were very pleased with the satisfaction coming from employees about the benefits of coverage for them and their families.

Now, these things to us are a very strong affirmation. And second, we had a premium supplementation fund built into our law to supplement the premiums of businesses that could demonstrate by means-testing that they could not pay the premiums. And in fact, in 20 years, only five businesses have applied, only $85,000 has been tapped from the original million-dollar fund, and it is now a multimillion-dollar fund gaining interest.

So while we were concerned about the possibility that small businesses might be very adversely affected, and we put the law into place during a peak period of unemployment, in fact businesses have accommodated very well.

The myths about Hawaii are that we are all healthy because of excellent weather, or maybe superior genetics. I hear that often. We have a lot of Asian Americans, and they are supposed to be extremely healthy and not require any health care. Or that life styles are exemplary in Hawaii, or finally, that we are an island situation, locked in, businesses cannot leave, and only in an island situation could things like this occur.

I want to point out that we have good data to support the fact that none of these myths are valid. There are many places at our same latitude around the world, and there is no place with the health results of Hawaii or the health statistics of Hawaii.

Certainly, southern Florida or San Diego have great weather, but unfortunately they cannot claim to have the kind of health care costs that we do.

Genetics and life style, we can dispute very, very effectively with Centers for Disease Control data that compares all States.

And the island status issue is that small businesses cannot leave. Well, the small businesses that do not provide health insurance are the service businesses. They cannot leave anyway. They are locked to their consumers and their customers.

The real reason Hawaii succeeds is because we have reduced unnecessary emergency room use by 50 percent; we have a hospital bed ratio of 2.6 instead of 3.7 U.S. average per 1,000; we have inpatient days reduced by 12 percent per capita, with enormous savings deriving from that; and surgeries reduced by nearly 40 percent over U.S. rates. And we are not rationing care.

We have increased investments in public health, and therefore we have the lowest infant mortality, and we have reduced our child abuse rates by 50 percent in the last 5 years through intervention, and we have reduced our HIV infection rates.

So I want to point out that what Hawaii has by virtue of its employer mandate is a level playing field. I can tell you that the rich-

est employee in Hawaii and the poorest employee have the same one-tiered health care system. What the richest employee can buy is amenity—plastic surgery, liposuction, prayer partners—you name it; whatever people want to buy on the outside. But frankly, it is not providing longer longevity or a better quality of life or reduced morbidity and mortality.

I would like to say that Hawaii is not a blueprint, and we do not claim to be. We need national health care reform. We are part of the American health care system unless it changes. We cannot control our 10 percent rate of cost increase. But if you talk to Bank of Hawaii, which has subsidiaries in New York and Phoenix and San Francisco and Hawaii, they are paying $300 a month for health insurance for their employees in Hawaii, $900 in New York, $600 in Phoenix and in San Francisco. A 10 percent rate of increase in Hawaii is $30 a month for them; it is $90 a month in New York. We are not catching up with the costs on the mainland.

I think the point is that we are part of the American health care system. We cannot control drug costs or Medicaid and Medicare increases by ourselves, so we do need reform, and we like the Clinton strategy. But the reason we are in front——

The CHAIRMAN. I will give you just a couple more minutes.

Dr. LEWIN. OK. I will wrap it right up.

The reason we are in front is because of the employer mandate. There is no doubt about it. It is the foundation for the other things that I have had the privilege of effecting in the last few years. Without the employer mandate, I could not have done it. We had 17 percent of our public uninsured in 1974. When I came as director of health, only 4 percent were uninsured. So I could go after that gap group aggressively, and we could afford to take them on. We could not have done that without the employer mandate.

We know in Hawaii that America can achieve a very high quality of care, excellent health care system, one that most of us are used to, and we can do it for approximately 10 percent of our gross national product. We know that that is possible, and we know that we will still have room left, then, to bring the poor, the disenfranchised, and those who are outside the system on with dignity.

We think that the employer mandate part is the most essential key link to doing that.

Thank you, Senator.

The CHAIRMAN. Thank you very much.

[The prepared statement of Dr. Lewin follows:]

PREPARED STATEMENT OF DR. JOHN C. LEWIN

Thank you for the opportunity to contribute to national health policy development by outlining Hawaii's health care reforms. We appreciate the opportunity and recognition you have given by inviting us here today.

Hawaii is often thought of as a tropical paradise. What isn't known is the fact that we have one of the best basic health systems in the nation. Our system delivers high-quality care for low cost, despite our high cost of living. While we emphasize early intervention and outpatient treatment, Hawaii enjoys high tech tertiary care programs as advanced as any state or nation. The key to our success is our state's longstanding commitment to ensuring that basic health care is available to all our people -- our system offers access to coverage to all and in fact has covered about 98% of our people. Another cornerstone is Hawaii's innovative health care community which experimented with short hospital stays, outpatient surgery, and preventive health programs some time before they became the norm on the mainland United States.

Our state has a mandated employer benefits program, the only one of its kind in the nation, a Medicaid program which reflects our people's high commitment to those in need, and coverage to those left in the gap between these other programs through our new State Health Insurance Program (SHIP). We don't offer these programs as panaceas for the national crisis of the uninsured. But, they <u>are</u> applicable to the national debate on health care, and we are glad to offer our contribution at this forum. Together, we can contribute to national policy in health care.

Today, I am here to apply Hawaii's experience to the economic effects of the Clinton Health Care Plan. I will not attempt to discuss the many elements which might be covered here, but rather will focus on a major area of controversy on which our experience may shed important light -- that of the economic effects of an Employer Mandate.

BACKGROUND

The economic impact of an employer mandate is controversial. Opponents claim there will be significant job losses as well as serious economic damages to small businesses. Such allegations are certainly based on the assumptions that small businesses are to be incorporated into a health insurance mandate that reflects the existing adverse environment. However, an employer mandate which is associated with insurance market reform, community insurance rating, a fixed and broad standard benefit package, appropriate utilization controls and a level playing field

of assured and equal participation by all businesses and all workers has not been the experience of the small business community in America except in Hawaii. The level playing field of above-described conditions which accompany Hawaii's mandate have provided a workable framework in which nearly all businesses have been able to both thrive and incorporate the cost of health insurance for employees through increases in the costs of their goods and services. In other words, in Hawaii, after the passage of the Prepaid Health Care Act the cost of a hamburger did increase slightly, as did the cost of dry cleaning a shirt, as did any other cost of either goods or services produced by businesses which formerly had not provided health insurance for their workers. However, all of these businesses were affected equally and at the same time.

The allegations of opponents to an employer mandate maintain that the high costs of health insurance today cannot be accommodated in small businesses through efficiencies or higher prices of goods and services, although critics fail to recognize that they cannot escape such costs through federal and state taxation and increasing health insurance costs to cover the uninsured populations.

Critics further project that many employers will react to an employer mandate by eliminating low-wage employees or going out of business completely. Such allegations fail to take into account the effects of lower insurance costs resulting from community insurance rating and reduction of administrative costs in health insurance through a well-designed employer mandate. Through reductions in cost shifting, resulting in lower public taxation costs, and lower health insurance costs, many small businesses who presently insure their workers will experience significant savings, which would presumably result in the ability to create new jobs in these businesses. Further, Hawaii's small businesses were given the opportunity to opt-out of our employer mandate in the early 1980s when the law was successfully challenged on the basis that it violated the Employees Retirement Income Security Act of 1974 (ERISA). It took Hawaii nearly two years to reestablish the law through an ERISA exemption, yet there is no evidence of any small businesses who discontinued insurance coverage during that period. The reason most often cited by small business representatives for the continuity of universal coverage during this period is that businesses had both become accustomed to having health insurance benefits coupled with employment, and they acknowledged the peace of mind and security among their employees related to guaranteed health coverage.

We must differentiate between the ideological concerns of small businesses related to government mandates over their domain as compared to concerns about their economic effects resulting from Amercia's only employer mandate in actual practice, namely Hawaii's mandate. Allegations of those who claim an employer

mandate cannot succeed economically relate more to ideological assumptions than sound data. We believe that it is time for a reality check. Hawaii is that reality check because we have twenty years of actual exeperience to add to the national discussion.

HAWAII PREPAID HEALTH CARE ACT

The keystone of Hawaii's health care reform system rests in its Prepaid Health Care Act. Adopted in 1974 in a time of high unemployment, this measure was effected after six years of study and policy development.

The Prepaid Health Care Law is the nation's first and only employer mandate. Employers are required to provide health insurance to their employees. Costs are shared. The employee may pay up to 1.5% of monthly wages, or up to half the premium cost, whichever is less. The employer pays the balance. Dependent coverage is optional. Under the law, employers may provide benefits through self insurance as long as the benefits offered meet the provisions of the Act and the plan is approved by the Hawaii Department of Labor. There are coverage alternatives, a fee-for-service plan and a health maintenance plan. The fee-for-service plan -- most used in Hawaii -- provides a good package of diagnostic and treatment services, using co-payments to reduce over utilization. The HMO (health maintenance organization) plan provides a generous package of benefits.

Basically, any employee who works over 20 hours a week is covered by Prepaid Health Care. Because the program is administered in conjunction with temporary disability and workers' compensation insurance in our State's Department of Labor and Industrial Relations, no large state bureaucracy was created to administer Prepaid Health Care. A Premium Supplementation Fund assists small employers who cannot, because of economic limitations, provide the insurance, and helps employees whose employers have gone out of business or who have not provided for the insurance. This fund has had minimal use over the 18 years of the program. Administrative and legal sanctions are available for use when employers do not provide the mandated coverage.

Excluded from the provisions of the Act are government employees (who have their own alternatives for coverage), seasonal agricultural workers, real estate and insurance agents working on commissions, individual proprietorship members in small family business, and government assistance program recipients.

AN OVERVIEW OF HAWAII'S ECONOMY

Hawaii's economy is based on three major products: tourism, defense expenditures and agricultural products. Direct income from these three products entailed 44.6% of the state's Gross Domestic Product in 1975 and 47.9% in 1991, with the growth of tourism during the period being the dominant feature of economic change. Major industries in Hawaii are services, government, finance, retail trade, transportation and construction (Chart 1). Gross state product, adjusted for inflation, has grown consistently throughout the period 1972-92 (Chart 2). While it may be noted that Hawaii's economy is less diverse than that of the nation, it is typical of many states and does have a concentration of economic activity in the service, retail trade and construction sectors, all of which are cited as sectors in which an employer mandate would have a significantly negative impact.

Hawaii is also a small business state. As can be noted from Chart 3, in both 1975 and 1990, 98% of the businesses in Hawaii employed less than 100 workers, and 95% employed less than 50. In 1990, small businesses employing less than 100 persons entailed 51% of the total employees. Again, with such a high proportion of small businesses, it would be expected that an employer mandate, if it were to have a negative impact, would show that impact in a state with such a high proportion of small businesses.

BUSINESS EFFECTS

None of the negative effects projected for an employer mandate appear in Hawaii's business experience:

- Chart 4 shows the steady growth of the number of businesses in Hawaii during the period 1970-1991. There does not appear to be any fall-off in the growth of businesses either immediately or in the long term after the effective date of the Prepaid Health Care Act (January 1, 1975).

- In Chart 5, new job creation for the period 1969-1989 is displayed. Note that new jobs continued to be created after the effective date of the mandate and that, in fact, every succeeding year saw job growth with the exception of 1981, a period of exceptional economic downturn. Instead of the job loss which would seem to be predicted by the current studies, Hawaii has seen job growth.

- Loss of jobs would also be measured by unemployment levels. If, as predicted, an employer mandate would impact business negatively, sizeable unemployment should result, as employers shift to automation, or reduce employees to reduce the extra costs of insurance coverage. Hawaii's experience shows that this did not happen. Chart 6 shows that unemployment, high before the mandate, has actually declined in the years since its implementation to the point that throughout the period since 1980, our unemployment rate has been consistently below that of the nation. For every year since 1986, in fact, it has been below the 5% level identified by economists as "structural unemployment."

- Business failure is another dire predicted consequence of an employer mandate. With the burdensome costs of health insurance, the theories hold that some or many businesses will fail. Again, Hawaii's experience belies this assumption. We do not have data prior to 1977 on this item, but Chart 7 shows how Hawaii ranks vis a vis the nation on the Dunn and Bradstreet index of business failures since 1977. As can be noted, Hawaii's rate has been well below the national rate for every year since 1977.

- Certain projections have focussed on certain types of small business jobs as the focal point of negative impact of an employer mandate. Projections are made that low wage service industry jobs would be those most impacted, as the high cost of insurance impacts the low compensation package for low income workers. Health insurance costs would raise the total compensation package to a point that it is economically not viable for the employer to raise prices, depress wages or find economies in operations to offset the increase, it is felt. The inevitable projection of job loss in these job categories results. Hawaii's experience with these categories of low wage employees does not bear out the projections. Chart 8 shows the growth of employment in the restaurant industry, one of the industries most fearful of a mandate nationally. As can be noted, growth in restaurant jobs has been consistent across the period 1975-1986 after the mandate was passed, with the only slow down being in the early 1980s.

- Chart 9 shows the steady growth in service industry jobs after the mandate. For the period 1974-1984, service industry jobs increased from 74,000 to almost 104,000. A decline in construction jobs is also evident, but this has been attributed by our analysts to a cyclic decline in major capital investments rather than an increase in health care costs. Construction jobs in Hawaii have had a high proportion of unionized members with health care benefits.

- A recent study by corporate demographer David Birch called Hawaii the number one "entrepreneurial hot spot" in the U.S. The study focused on the number of surviving start-ups by young companies during 1988 through 1992. Honolulu came in second among medium-sized cities, and our neighbor islands ranked first among rural areas. Chart 10 shows the results of the Cognetics Inc., survey for states.

All of this indicates to us that, in fact, dire predictions of job loss from a mandate are just that -- predictions. Our actual experience indicates that no negative impact is evident in business/job growth, unemployment, or business failure in Hawaii.

In fact, we believe that the mandate actually had positive effects on employers. Because there are few uninsured in Hawaii, our hospitals report a level of uncompensated care much lower than the U.S. as a whole. Thus, little uncompensated care costs are factored into the insurance rates of business. Businesses who do the socially right (and legally required) thing in Hawaii are not forced to pay for the health care for workers of businesses who do not. Moreover, businesses enjoy fair insurance practices which give them accessibility to coverage at reasonable costs. Our businesses know this, and in a recent survey, 55% of them said they would support an employer mandate were it to be reproposed today. That is very significant, given the high proportions of small businesses said to oppose a mandate nationally. In fact, our system belies the fears, and our businesses know it.

EFFECTS ON ACCESS

The effects of Prepaid Health Care is evident on access. In 1971, a survey show that those without hospital insurance were also 12% of our population and those without physician insurance were more than 17% of the population. Implementation of Prepaid Health Care significantly reduced those percentages. Estimates of those newly provided with health insurance range to more than 46,000. A survey done in 1970 by the Department of Health estimated that only 3.9% of Hawaii's people lacked coverage. Other people were provided better coverage. The Department of Health estimates that those figures grew with the shrinking of Medicaid during the 1980s to approximately 5% in 1987-1988.

A more complete analysis of the Act and its effects, particularly its effects upon health and health status, is contained in an article by myself and my Deputy Director, Dr. Peter Sybinsky, recently featured in the Journal of American Medical Association (JAMA), "Hawaii's Employer Mandate and Its Contribution to Universal Access." We have attached (Attachment 1) the article for your Committee's use.

MYTHS ABOUT HAWAII

In addition to the effects of an employer mandate, Hawaii has a number of lessons which can be of assistance in national health care policy. Many people do know about our experience and many misconceptions exist:

1. Hawaii's geography and climate is healthier to begin with.

   Hawaii is located between 18-23 degree N. Latitude. Other islands at or near the same latitudes are: Taiwan, Hainan (China), Haiti/Dominican Republic, Cuba, and, in the southern latitudes, Madagascar. None of these comparative island environments are particularly healthy, per se.

2. There's less stress in Hawaii than there is on the mainland.

   The cost of living in Hawaii in 1990 was 34% above that of the average mainland urban area. Housing costs are extremely high (the median rental cost in 1990 was $960, 240% of the mainland median; the median cost for purchase of a home in 1989 was $267,000). This leads to a high percentage of two wage earner families and concomitant family stress over economics, latch key children, etc. In Hawaii, we have our share of stress.

3. In Hawaii, people live a healthier lifestyle.

   Despite a climate that should make such a lifestyle more possible than anywhere else, that lifestyle remains an elusive goal. In a recent survey, Hawaii ranked below the national median on 4 of 7 healthy lifestyle indicators: no leisure activity; greater sedentary lifestyle; more "binge" drinking; and greater drinking and driving

4. Because 67% of its population is Asian - Pacific Islander, which is healthier in national statistics, Hawaii's people are healthier per se.

   In fact, our population is not innately healthier. When comparing on a Centers for Disease Control (CDC) index of premature mortality, the four large population groups in Hawaii (Caucasians, Japanese, Filipino and Hawaiian), Caucasians, Japanese and Filipinos have roughly the same levels of premature mortality. It does not appear in Hawaii, then, that these Asian groups differ significantly healthwise from Caucasians. Hawaiians, however, have twice the rate of premature mortality than the other groups. Because of the small size of this group within the national "Asian - Pacific Islander"

category, this poor status could well be missed. Because persons of Hawaiian descent make up 20% of Hawaii's people, actually this poor status negatively impacts on Hawaii's health figures.

5. Hawaii has been successful with an employer mandate because "its businesses can't move away."

While, on the surface, this argument would seem to hold, as Hawaii consists of islands 2,500 miles from the U.S. mainland, a deeper look suggests that this might be an erroneous assumption. Hawaii is 4-1/2 hours by airplane from the U.S. mainland, about the same distance as San Francisco is from Washington, D.C. It is connected by satellite and electronic media with financial centers worldwide. While a business person might spend a few more hours in air travel in moving from Hawaii to another state, there are not real "barriers" to such a move. A more realistic concern is the ability of a business to move across state borders (in the event the state were to enact an employer mandate) and service its previous service area from outside the state. Obviously, this could not happen in Hawaii, but it is important to note that such a problem is not generic, but would apply only to specific businesses and business locations. While the problem could be a real one for the computer industry in New England, for example, such experience should not be generalized to the fast food industry in Oregon. For small businesses, even a relatively small distance precludes such a solution and in most of the United States distance, while not as extreme a factor as in Hawaii, does preclude such moves.

LESSONS FROM HAWAII

Because our system provides up-to-date American health care services, uses insurance as its mechanism of financing and operates within the same legal/constitutional framework as other states, we believe our experience has real relevance to the nation's efforts to bring access to all of its people, at affordable costs. In brief, these are:

1. Mandated employer coverage can be an effective tool for universal access -- without negative impact on business.

Hawaii's employer mandate brings large numbers of people under the umbrella of health care coverage. While this approach could be criticized as being "anti-business," it actually is in accord with America's faith in the free enterprise system to find cost-effective solutions to complex problems.

Through an employer mandate, government defines the extent of coverage and uses the competitive marketplace to provide that coverage costs effectively and efficiently. By requiring employers to cover their employees, an employer mandate avoids complex governmental bureaucracies and allows business to get the job done well.

Data and experience shows that, contrary to small business fears, our mandate has not brought about a bad business climate in Hawaii. Business growth and unemployment have not been impacted by the mandate despite concerns expressed prior to our mandate's passage which mirror the same arguments we find against a national employer mandate. These fears did not, in fact, prove to be substantiated then and we do not believe they are substantiated now. Our employer mandate has leveled the playing field for all employers and has ensured a strong package of health care benefits for all.

2. Insurance reform is vital to the success and equity of an employer mandate. What is also quite clear is that an employer mandate helps to ensure that insurance reforms are successful.

It is only fair that a mandate be accompanied by affordable insurance rates, which are possible in Hawaii through community rating, and the appropriate prohibition of exclusionary practices. Our community rating is voluntary, a likely product of the important role of our two large non-profit insurance providers in Hawaii's market. This voluntary modified community rating system works to keep our rates among the lowest in the nation. The insurers have been able to maintain this system without a specific legislative mandate because all employers must purchase coverage. Because all employers are in the risk pool, community rates are affordable. Because the insurance companies must compete, the market, not governmental controls, keeps the rates competitive. Thus, insurance reforms are necessary to the success of an employer mandate but the mandate is also likely to assist in making the insurance reforms viable for insurance companies.

3. Primary health care works, not only to resolve health needs, but to contain health care costs.

Historically, Hawaii's doctors emphasized outpatient care instead of hospitalization. Today's modern practice patterns reflect this orientation. Our Prepaid Health Care Act and the other elements in our system make it possible for most people living in Hawaii to finance this care. Today, our health indicators show the results of primary care. As noted in our recent

article in the Journal of American Medical Association, Hawaii has low infant mortality and low rates of premature death due to chronic disease such as heart disease and cancer. This is reflected in our use of expensive inpatient and emergency room services. As Table B, in the JAMA article shows, utilization rates for the high cost modalities is well below the national average. Early detection of potentially life threatening conditions results in low premature mortality and low hospitalization. Our people are healthier not because of unique genetics, healthy climate or high tech medicine, but because they have access to primary care.

Bringing basic health services to all Americans will not only help to improve their status but should work to reduce health care costs. Far from adding to the costs of the systems, it will actually make the system less expensive in the long run.

This is suggested by our systems experience. Recent analysis of Hawaii's health care costs suggests that our costs for health care as a share of Domestic Product are closer to those of Canada, Germany, France and Japan than to that of the rest of the United States. Despite Hawaii's high cost of living, health care in our State is less expensive. We have attached this article, Hawaii Medical Journal, "Comparison of health expenditures in U.S. and Hawaii economies," (Attachment 2) for your committee's review.

A solid package of standard benefits is a vital component of any health care reform effort.

A broad standard benefits package, emphasizing primary, outpatient, and community care, but including a comprehensive spread of benefits extending from preventive services to inpatient and catastrophic care, is necessary to contain overall costs. Hawaii's experience supports inclusion of benefits and services that are demonstrated to be clinically and financially effective and appropriate and that collectively reduce unnecessary emergency department, inpatient, and high-technology care by design.

5. Hawaii show that states are important actors in affecting health care reform.

Thanks to its ERISA exemption, Hawaii, though a small state, has demonstrated that an employer mandate can be successful in reducing the numbers of uninsured. Even the small number remaining has not been reached through our SHIP. Further, the voluntary efforts of Hawaii's two major insurers have produced health care coverage at costs well below other areas of America. These efforts have set the stage for further reform in our

Health QUEST program. Under national reform, states like Hawaii can and must have flexibility to tailor their system to the specific needs of their people.

In closing Hawaii's experience show that health reform can be accomplished, while still maintaining the basic strengths of America's health care system. Regardless of the approach our nation takes, ultimately, reforms must be rooted on these three principles:

1. Public health and prevention must be a priority to foster a healthier and more responsive society. Unless each one of us adopts responsible health practices, our health care needs will increase, wiping out the fruits of any cost containment efforts we may adopt.

2. Primary care, focusing on a community-based medical home for each citizen, must be the first priority and foundation of access efforts. Primary care is effective in lowering the need for more expensive care. It is vital that each of us has such a regular source of care, which will best be able to guide us through the complexities of the health care system.

3. Government doesn't need to run a health care system. Its presence in delivery of care, setting of reimbursements, or payments serves mostly to stifle the innate creativity which has made American health care the best in the world. Government does not need to set and enforce rules by which a fair and equitable marketplace can operate.

We believe that awareness of and commitment to these principles will assure ultimate success to our health care reform endeavors. In any case, we all must move forward at both state and federal levels to achieve health care reform for America. Hawaii joins enthusiastically in this effort.

Thank you and ALOHA.

The CHAIRMAN. Mr. Pauly.

Senator WOFFORD. Mr. Chairman, could I just say to Mark Pauly that I welcome him warmly. We have been in very instructive conversations for a long time.

I must leave because of a pre-existing commitment, and will be back as soon as I can, and I will study his testimony with the usual interest and respect I give to what he and his colleagues at the University of Pennsylvania, The Wharton School, and the Leonard Davis Institute have done.

I will be back as soon as I can. Thank you.

The CHAIRMAN. Thank you very much.

Mr. Pauly.

Mr. PAULY. The objectives of the administration's health reform proposal, to change the current health care system in order to provide universal coverage and a lower rate of growth in medical spending, are certainly praiseworthy. I am in favor of reform. The key issue here is what is the best vehicle to take for reform.

And in line with my attempt to offer advice and caution, there are five potential problems with the administration's plan in its present form that I want to comment on in the hope that some alteration may be possible.

First, the plan in its present form will cause a substantial and probably inequitable reduction in real take-home pay for the 40,000 workers currently not receiving employment-based health insurance.

Second, it will potentially cause substantial unemployment among low-wage uninsured workers, whose money wages cannot fall below the minimum wage.

Third, it will cause reductions in work effort by low-wage and probably by high-wage workers. Fourth, it will distort incentives to organize small low-wage firms, and finally, it will wipe out the possibility of creating one million health worker jobs by the end of this decade.

The key to understanding the adverse consequences of a mandate that employers pay part of worker compensation in the form of health insurance premiums is the recognition that under such a mandate, the entire cost of health insurance will ultimately fall on workers. Whether the payment for the insurance is withheld from the worker's compensation before the paycheck is calculated or after, the effect is the same—higher benefit payments imposed on all workers will reduce money wages. After all, the total amount an employer can afford to pay an employee depends on the employee's productivity, and a legally mandated benefit payment, unlikely to affect productivity, must cut into money wages or other benefits.

This is why the overall employment effects of mandated coverage are fairly small, because the primary effect is not on the number of jobs but on the wages per job.

While the administration's proposal does contain some subsidies for workers in low-wage firms, it translates into a head tax for workers in firms with wages high enough that the employer's share of the premium is less than the average wage times the tax or contribution rate.

For instance, an employee who gets single coverage in a firm with more than 50 employees will pay 80 percent of the premium,

estimated to be about $1,420, regardless of his or her wage level, for all firms with average wages above $18,000 per year.

Even with the subsidies, the overall tax structure is highly regressive because it takes the form of a head tax for firms with average worker wages above some cut-off, and a payroll tax for firms with lower average wages.

A head tax is not the worst tax in the world. After all, it appeared to the Thatcher Government, if not to the rest of the British electorate. Such a tax does not in itself distort incentives. However, it is brutal in terms of equity, since it does not reduce the obligatory payment at all as wage income falls. Some, perhaps including some in Hawaii, might even regard such a pattern of uniform obligatory payments for most workers as fair, but that judgment, if it is to be made, should be made explicit.

For those workers whose money wage is not enough above the minimum wage to permit it to be reduced by the share the employer is required to pay, there is a different consequence—job loss. The impact of a mandated benefit is much like an increase in the minimum wage, but with a twist—the increase can be much larger than any increase in the minimum wage we have ever seen, as much as $1.67 an hour for low-wage full-time workers in firms with high average wages who get family coverage.

Moreover, while increases in the money minimum wage quickly get eroded by inflation, the cost of health benefits will not. This means the recent studies showing modest, though positive, unemployment effects of minimum wage increases provide little guidance to estimate effects here.

The other major effect on total employment comes from possible work disincentive effects of higher implicit or explicit tax rates. This phenomenon will potentially appear in two places. Most obviously, since the required employer contribution tax rate will rise for firms with fewer than 50 employees with money wages, there will be an incentive to keep average wages down.

The implicit marginal tax rate embodied in the proposed schedule for small firms is as high as 18.4 percent of additional wages.

Second, when it proves impossible to make the kinds of cuts in Medicare and, most implausibly, Medicaid that are envisioned, taxes on upper-income workers will need to be raised, and there will be adverse incentive effects there.

Finally, the complicated pattern of subsidies proposed, especially to low-wage firms and self-employed, will set up perverse incentives with regard to firm employment patterns and structure—incentives so perverse as to overwhelm the so-called "job lock" distortions.

The reason is simple. Under the plan, workers get a bigger subsidy if the employment group is small and the average wage low. This offers an incentive to split off low-wage workers into separate small firms in order to maximize the subsidy.

For instance, at a firm with 100 employees, half with wages of $40,000 and half with wages of $15,000, all workers can gain by splitting the firm into two 50-worker units, since the firm with 50 low-wage workers will get a subsidy, and the firm with 50 higher-wage workers will pay no more for their health insurance than would have been paid in the initial configuration.

Additional distortions arise from the treatment of self-employed workers and early retirees. The amount of mischief that will be done by such perverse incentives is hard to quantify but, given the increasing flexibility of employment relationships among American workers, is sure to be substantial.

In its efforts to hold down the explicit budget cost of health reform, the administration has developed a plan that is the worst of both worlds. It is too regressive to be equitable, but too distortive to be efficient. The fundamental overall problem with the administration's strategy is that it proposes to use the employment relationship as the basis for its mandated coverage.

But the employment-related group, while appropriate for some sets of workers, is for many an inferior vehicle to arrange insurance purchasing.

The final impact on employment comes not from the mandated benefits but from the limit on spending growth due to take effect after 1994. In a labor-intensive industry such as medical services, limits on spending growth have to translate into reductions in raises or reductions in jobs added.

The medical care sector has been one of the few bright spots in our moribund economy, adding 300,000 jobs a year and offering a growth in wages per worker in the 1980's more than 40 percent greater than average. While limits on spending growth will not necessarily take away jobs, they will halt the creation of new jobs, to a virtually complete stop by the year 2000. Of course, the potential medical workers may get jobs elsewhere. The only sensible reason to curb medical spending growth is, after all, a judgment that there should be more of other kinds of output and less growth in jobs providing medical care quality and technology.

However, while some medical workers are highly skilled, there are many decent jobs in this industry, often held by women and minorities, that do not require sophisticated training. It is these jobs that are most at risk from a medical spending cap.

My judgment is that between 1996 and 2000, the administration's plan will result in the creation of approximately one million fewer health sector jobs relative to baseline, many of which will be difficult to replace elsewhere in the economy.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Pauly follows:]

Prepared Statement of Mark V. Pauly

The objectives of the Administration's health reform proposal -- to change the current health care system in order to relieve universal coverage and lower rate of growth in medical spending -- are certainly praiseworthy. However, there are five potential problems with the plan in its present form. First, it will cause a substantial and probably inequitable reduction in real take-home pay for the 40,000 workers currently not receiving employment-based health insurance. Second, it will cause substantial unemployment among low wage uninsured workers whose money wages cannot fall below the minimum wage. Third, it will cause reductions in a work effort by low wage and probably high wage workers. Fourth, it will distort incentives to organize small low wage firms. Finally, it will wipe out the possibility of creating 1 million health worker jobs by the end of this decade.

The key to understanding the adverse consequences of a mandate that employers pay part of worker compensation in the form of health insurance premiums is the recognition that, under such a mandate, the entire cost of health insurance will fall on workers. Whether the payment is withheld from the worker's compensation before the paycheck is calculated or after, the effect is the same: higher benefit payments imposed on all employers will reduce money wages. After all, the total amount an employer can afford to pay an employee depends on the employee's productivity, and a legally mandated benefit payment, unlikely to affect productivity, must cut into money wages or other benefits.

While the Administration's proposal does contain some subsidies for some workers in low wage firms, it translates into a head tax for workers in firms with wages high enough that the employers' share of the premium is less than the average wage times the tax rate. For instance, an employee who gets single coverage in a firm with more than 50 employees will pay 80 percent of the premium (estimated to be about $1420), regardless of his or her wage level, for all firms with average wages above $18,000 per year. Even with the subsidies, the overall tax structure is highly regressive, because it takes the form of a head tax for firms with average worker wages above some cutoff, and a payroll for firms with lower average wages.

A head tax is not the worst tax in the world; after all, it appealed to the Thatcher government (if not to the rest of the British electorate). Such a tax does not, in itself, distort incentives. However, it is brutal in terms of equity, since it does not reduce the obligatory payment at all as wage income falls. Some might even regard a pattern of uniform obligatory payments for most workers as fair, but that judgment should be made explicit.

For those workers whose money wage isn't enough above the minimum wage level to permit it to be reduced by the share the employer is required to pay, there is a different consequence: job loss. The impact of a mandated benefit is much like an increase in the minimum wage, but with a twist: the increase can be much larger than any increase in the minimum we have ever seen -- as much as $1.67 an hour for low wage full time workers in firms with high average wages who get family coverage. Moreover, while increases in the money minimum wage quickly get eroded by inflation, the cost of health benefits will not. This means that recent studies showing modest (though positive) unemployment effects of minimum wage increases provide little guidance to estimate effects here.

There are, as far as I am aware, no models to predict the overall impact of mandates on low wage workers jobs. It is reasonable to believe that those low wage small businesses currently providing insurance who receive subsisides will translate most of that subsidy into higher takehome pay, not more jobs. On the other hand, there are about 40 million workers who do not now pay for insurance as part of their job, of whom at least 15 million earn $6.50 per hour or less, ans so would be at risk for minimum wage effects. I would conjecture that at least 15% of these workers, or 2.2 million workers, are so close to the minimum wage that they will be priced @ of the labor market after the imposition of a mandated employer contribution.

The other major effect on total employment comes from possible work disincentive effects of higher implicit or explicit tax rates. This phenomenon will potentially appear in two places. Most obviously, since the required employer contribution tax rate will rise with wages for firms with fewer than 50 employees, there will be an incentive to keep average wages down. The

implicit marginal tax rate embodied in the proposed schedule is as high as 18 4 percent of additional wages Second, when it proves impossible to make the kinds of cuts in Medicare and (most implausibly) Medicaid that are envisioned, taxes on upper income workers will need to be raised, there will be adverse incentive effects there

Finally, the complicated pattern of subsidies proposed will itself set up perverse incentives with regard to firm employment patterns and structure -- incentives so perverse as to overwhelm the so-called "job lock" distortions The reason is simple: under the plan, workers get a bigger subsidy if the employment group is small and the average wage low. This offers an incentive to split off low wage workers into separate, small firms in order to maximize the subsidy. For instance, at a firm with 100 employees, half with wages of $40,000 and half with wages of $15,000, all workers can gain by splitting the firm into two 50-worker units, since the firm with 50 low wage workers will get a subsidy, and the firm with 50 higher wage workers will pay no more for their health insurance than would have been paid in the initial configuration. Additional distortions arise from the treatment of self-employed workers and early retirees The amount of mischief that will be done by such perverse incentives is hard to quantify but, given the increasing flexibility of employment relationships among American workers, is sure to be substantial.

In its efforts to hold down the explicit budgetary cost of health reform, the Administration has developed a plan that is the worst of both worlds It is too regressive to be equitable, but too distortive to be efficient The fundamental overall problem with the Administration's strategy is that it proposes to use the employment relationship as the basis for its mandated coverage The only reasons for doing so are force of habit or historical accident, and the attractiveness of financing a public program with an off-budget tax generated to confuse the electorate. But the employment-related group, while appropriate for some sets of workers, is for many an inferior vehicle to arrange insurance purchasing

The final impact on employment comes not from the mandated benefits but from the limit on spending growth due to take effect after 1995 In a labor intensive industry such as medical services, limits on spending growth have to translate into reductions in raises or reductions in jobs

added. The medical services sector has been one of the few bright spots in our moribund economy, adding 300,000 jobs a year and offering a growth in wages per worker in the 1980s more than 40 percent greater than average. While limits on spending growth will not necessarily take away jobs, they will halt the creation of new jobs -- to a virtually complete stop by the year 2000. Of course, the potential medical workers may get jobs elsewhere -- the only sensible reason to curb medical spending growth is a judgment that there should be more of other kinds of output and less growth in jobs providing medical care quality and technology. However, while some medical workers are highly skilled, there are many decent jobs in this industry often held by women and minorities that do not require sophisticated training. It is these jobs that are most at risk from a medical spending cap. My judgement is that, between 1996 and 2000, the Adminstration's plan will result in the creation of approximately 1 million fewer health sector jobs, many of which will be difficult to replace elsewhere in the economy.

The CHAIRMAN. Mr. Klerman.

Mr. KLERMAN. It is both an honor and a pleasure to be here today to testify on my joint research with Dana Goldman, also at Rand, about the magnitude of the job loss likely to occur as a result of the proposed Health Security Act. We have prepared a written statement describing our analysis in detail, and we ask that it be entered directly into the record. For the committee, I will briefly summarize the analysis, and I will then be happy to answer any questions you might have.

The country is now engaged in a great debate over health care reform. Many valid and important arguments have and will be made concerning the details of the President's plan and those of alternative plans. Among those arguments has been a prediction that health care reform will lead to the loss of several million jobs.

We believe that such estimates are incorrect. Our best estimate of the direct job loss due to health care reform is under one-half of one percent of total employment, so that direct job loss need not be a major consideration in the evaluation of the Health Security Act.

Let me explain how we arrived at our estimates. The fundamental question in evaluating the likely employment effects of health care reform is who will really pay for the mandated health insurance. Nominally, the President's plan requires employers to pay 80 percent of the required premiums. In response to such a mandate, employers can pursue some combination of four actions. First, a firm can do nothing, which will cause labor costs to rise and profits to be lower. Second, a firm can raise the prices it charges for its products. Third, the firm can lower wages. And fourth, the firm can reduce employment, possibly through attrition.

As we discuss in detail in our written statement, recent research on the incidence of mandated benefits suggests that most if not all of the increased labor costs—net of any Government subsidies—will be passed on to workers in the form of lower wages. If so, employers' total labor costs will not rise significantly, and they will have little reason to reduce employment.

The administration has frequently noted that the earnings of American workers would be considerably higher if health care costs had increased only at the general rate of inflation. Dr. Tyson said that this morning. So for example, if employers had not had to pay the higher health insurance premiums, they would have raised wages $1,000 since 1975.

The converse of that position is that if we require firms to provide health insurance, they will lower wages over the intermediate term. While lower wages for some workers are a potential disadvantage of the Health Security Act, this effect will be mitigated by subsidies. It is this assumption that workers themselves will pay for much of the health care in the form of lower wages which yields our lower employment effects.

This observation that employers will pass on the cost of the insurance premium to workers in the form of lower wages breaks down for low-income workers. The Fair Labor Standards Act, the minimum wage law, prevents workers from paying their employees less than $4.25 an hour. For workers whose current earnings are less than the sum of the minimum wage and the cost to the firm

of the health insurance benefit, health care reform will effectively raise the minimum compensation. In this sense, it will have effects analogous to an increase in the minimum wage.

There is a large literature on the effects of the minimum wage. That literature has recently been updated to reflect the 1990 and 1991 increases in the Federal statutory minimum wage. Contrary to the expectation of most economists and basic textbook theory, case studies of the recent increases fail to find any employment loss due to the increase in the minimum. Econometric studies over longer time periods attribute measurable, but small, job losses to changes in the minimum.

Putting together these two sets of assumptions—first, the shifting of costs to employees, and second, the analogy to an increase in the minimum wage—our best estimate of the effects of employment loss due to health care reform is about one-half of one percent of employment.

Our lower estimates of job loss, compared to several others that have been given, really fundamentally on the assumption that wages are flexible downward, so that employers will be able to pass on the costs of the mandated health insurance to workers. Experience in the American economy over the last 15 years suggests that there is considerable downward flexibility in wages over the intermediate term.

The magnitude of the actual job losses are likely to be quite sensitive to the details of the final health care reform legislation. Which firms will be eligible for the subsidies? How large will they be? Will they be phased out over time? How fast? And what restrictions will be put on the ability of firms to out-source labor and therefore change whether or not their workers are eligible for those subsidies?

Among the crucial details, it is important to note that under the Health Security Act, the subsidies go to firms with low average payroll. A firm with a high average payroll that considers hiring a worker at the minimum wage will pay the full premium, considerably increasing employment costs and giving the firm an incentive to out-source that work or to not hire the low-wage worker.

In our work, we have deliberately considered only employment effects due to firms laying off workers as a result of the requirement that they contribute toward their employees' health insurance. If health care reform succeeds in its goal of lowering health care cost inflation over the intermediate future, it would have positive effects on the economy as a whole, which would be likely to include higher wages and higher employment. Our estimates do not consider such positive effects.

On the other side, the legislation is likely to have two effects that will induce workers to be less inclined to work. First, health insurance will be guaranteed for both workers and nonworkers. Thus, it will not be necessary to work in order to get health insurance. Second, if individuals do work, their wages will be lower because employers will have allocated some of their compensation to cover the cost of the health insurance. Therefore, we will probably see fewer people working, by their choice, and these decreases are likely to be concentrated among low-income workers, mostly young people, and among early retirees.

On the other hand, these same reforms are likely to increase job mobility by eliminating the link between a particular employer and insurance, and may increase the desirability of low-wage jobs to welfare recipients by allowing them to keep their health insurance which they had as a result of Medicaid.

Finally, we would like to note that the magnitude of the changes involved in any reorganization of a major sector of the economy lead us to treat our estimates as informed guesses; unexpected consequences seem possible, if not likely.

Nevertheless, our estimates are, for reasons discussed in detail in our written testimony, considerably lower than many that have been widely cited by the opponents of the Health Security Act. We believe they represent best estimates at the present time, and they imply that significant job losses need not be a major concern in your evaluation of the President's plan and its alternatives.

Thank you.

[The prepared statement of Mr. Klerman and Dana Goldman follows:]

Prepared Statement of Jacob Alex Klerman and Dana Goldman

With the release of the proposed Health Security Act, the great debate about health care reform in the United States has entered a new phase. The fundamental issues in the debate involve how much heath care should be guaranteed to which Americans, the role of government in the reformed health care system, and who will pay the additional costs of extending health insurance to the currently uninsured[1].

Like other proposals, President Clinton's plan would extend the current employment-based financing of health insurance. The plan would require employers to pay 80 percent of the health care costs for each of their employees. The required plans are not inexpensive; the President's plan will cost approximately $1,800 per year for an individual policy and $4,200 for a two parent family policy.[2] Average annual earnings in the United States are approximately $24,500, and a full-time employee working at the minimum wage only earns $8,840 annually. Thus in the absence of subsidies, employer contributions towards health insurance for an individual earning the minimum wage would constitute 16 percent of a single worker's earnings (80% x $1,800 / $8,840), and 38 percent of earnings for a worker in a two-parent family (80% x $4,200 / $8,840).[3] For an individual with average earnings, projected premiums still constitute 5 percent of earnings for a single earner and 14 percent for earners in a two-parent family. Thus, health care reform may substantially increase labor costs for employers not currently offering health insurance.[4]

In a period in which employers have already pared employment and company balance sheets are lean, many policy makers and researchers are concerned about the potentially adverse effects of these cost increases on employment. A widely cited report by June O'Neill and Dave O'Neill, "The Impact of Health Insurance Mandate on Labor Costs and Employment" for the Employment Policies Institute, projects that health care reform would result in 3.1 million lost jobs.[5] In this testimony, we attempt to outline what is known about the likely employment effects of requiring employers to pay 80 percent of the health insurance costs of each of their employees.

The paper proceeds as follows. In the next section, we consider how an employer mandate might affect firm behavior. There we discuss recent research which finds that when government requires employers to provide benefits to employees, most of the cost is shifted to employees in the form of lower wages. We also note that for workers with very low hourly wages, it is illegal for firms to lower their wages enough to completely shift the cost of the employer contribution to employees. For employers of such low-wage workers, the mandate effectively becomes an increase in the minimum wage. We then discuss recent research on the employment effects of increasing the minimum wage.

In the second section, we discuss the methodology and results of the O'Neill and O'Neill study. For several reasons, we conclude that their estimates overstate the number of

jobs lost. In the third section, we use the recent evaluations of the minimum wage and new tabulations of the characteristics of the uninsured from the 1990 Survey of Income and Program Participation to derive our own simple aggregate estimates of the likely employment effects of the Health Security Act as it is currently formulated. The paper concludes with a summary of the key policy issues, as well as a discussion of details of the final legislation that would cause significant shifts in our estimates of employment effects.

1. The Employer's Perspective

1.1. The Employer's Choices

To provide perspective, it is useful to consider the choices facing a firm that does not currently offer health insurance. After health care reform passes, such a firm will pursue some combination of four actions.

- First, the firm can absorb the increased labor costs, in which case the new mandate will result in *lower profits*.

- Second, the firm could *raise the prices* it charges for its products. In so far as the firm's competitors also do not currently offer health insurance, their labor costs will also increase. Thus, while an employer may feel there is no leeway to raise prices now, doing so may be easier in the context of health care reform. If this occurs, consumers bear the burden of the mandate through higher prices.

- Third, the firm can *reduce workers' wages* so that its hourly labor cost remains unchanged after a transition period. Since earnings usually increase with job tenure, over the intermediate term firms need not actually reduce the wages of any current employee. Firms could simply forgo wage increases, or keep them below the rate that would have prevailed in the absence of health care reform.[6] This strategy may be particularly appealing to employers for young, low-wage workers. Evidence suggests that the median wage increase for workers starting at the minimum wage is 20 percent after the first year (Smith and Vavrichek, 1992). In addition, low-wage and uninsured jobs have considerably higher job turnover than insured jobs, so firms could explicitly lower wages as new hires replace departing workers (Klerman, Buchanan and Leibowitz, 1992).

- Fourth, the firm can *reduce employment* (possibly through attrition) of workers who do not warrant the increased compensation.

1.2. Who Pays for an Employer Mandate?

Recent experience with other employee benefit mandates suggests much of the increased costs to firms will be passed on to workers in the form of lower wages. Gruber and Krueger (1990) examine workers' compensation insurance. Worker's compensation insurance premiums vary widely across states and across time periods. Comparing changes in wages with changes in

insurance premiums (for high-risk occupations where the premiums are large), they find that firms passed on approximately 85 percent of the increase in workers' compensation costs to employees in the form of lower wages. In other words, for every $10 increase in worker's compensation premia, employee paychecks were reduced by $8.50. Because of this backward-shifting onto wages, they find little evidence of a significant decrease in employment.

Gruber (1992) explores the effect of state requirements that firms offering health insurance cover childbirth. In the 1970s, several states passed such legislation, and then in 1978 the federal government passed a national requirement. Gruber studies the relative changes in earnings for women of childbearing age before and after the legislation passed, across states which did and did not pass such legislation. He finds that essentially all of the increase in costs per female of childbearing age (between $250 and $950 in 1990) was passed on to the female population in the form of lower wages. He also finds evidence for a small reduction in employment.[7,8]

These results are both encouraging and discouraging for the proponents of a mandate. They are encouraging because they imply that, for most workers, the probability that any individual will lose his or her job due to health care reform is likely to be small. However, if health care reform is designed to provide an additional benefit of health insurance to the working poor, these results may be discouraging. After all, if employers backward-shift the costs of a mandate onto wages, then the currently uninsured will pay for much of their new health insurance out of their own earnings. Perhaps the working poor would prefer to buy other goods with these wages, such as food or housing.

From the perspective of the working poor, health care reform is regressive not simply because it would require them to buy health insurance in place of other goods they may prefer. Under the current system, if the uninsured get very sick, they will almost always receive some care at minimal cost in a public hospital or as uncompensated care. Health care reform forces them to buy insurance to pay for such care. This economic phenomenon has been called the "Samaritan's dilemma" and has been used as an argument for forcing people to buy income insurance such as Social Security, even though its effects are regressive (Summers, 1989).

Community rating provides further disincentives for the healthy to buy insurance. It requires that all individuals, regardless of age, race, sex, or health status, be charged the same premium. The currently uninsured are disproportionately young[9]. As a result, their health care costs are approximately 33 percent lower than the average, so they will implicitly subsidize the premiums of older workers.[10] Therefore, community rating implies that the young workers subsidize old workers; and since young workers earn less on average than old workers, low-wage earners subsidize high-wage earners.[11]

To address the regressive burden on low-wage earners and the large increase in employer costs, the Health Security Act includes subsidies to small employers and low-wage earners. These subsidies limit employer contributions for health care as a percentage of payroll. These caps range from 3.5 to 7.9 percent of payroll, depending on the average wage for

a full-time equivalent worker. For firms with fewer than fifty employees and average per-full-time equivalent payroll of less than $12,000, the contribution is capped at the lowest rate. Thus, contributions by small firms hiring predominantly minimum wage employees are limited to 3.5 percent of payroll. Since our earlier calculations suggested that employer costs could increase by as much as 38 percent, these subsidies significantly alter the burden of the mandate. Clearly, the impact on employment costs is dramatically lower with the subsidies. In addition, the subsidies make the proposed reforms more progressive.

1.3. Employer Responses to Increases in the Minimum Wage

The argument that employees bear the cost of lower wages breaks down for very low-wage workers. The Fair Labor Standards Act, known as the minimum wage law, provides that as of April 1, 1991 most employees may not be paid less than $4.25 an hour. For employees currently earning less than the sum of the minimum wage ($4.25) and the hourly cost to the employer of the health benefit (approximately $1.00 to $2.00 per hour depending on family composition), employers cannot legally cut wages in the intermediate term. Standard economic theory suggests that firms will cut employment until the remaining workers are each worth $5.25 to $6.25 per hour (Stigler, 1946). Some workers earning between $4.25 an hour and $5.25 to $6.25 an hour will lose their jobs.

The crucial question then becomes: How many? For employers of these low-wage workers, health care reform will act like an increase in the minimum wage (in this case minimum total compensation). Thus, we can look at historical experience to determine the job loss associated with a rise in the minimum wage. The magnitude of this employment effect is the subject of a large empirical literature on labor economics. That literature has grown considerably with studies of the increases in the minimum in April 1990 (from $3.35 to $3.85) and in April 1991 (from $3.85 to $4.25).

Contrary to the expectations of many economists and businessmen, the answer appears to be "not many." Few of the workers earning between a new, higher minimum wage and an old, lower minimum lose their jobs. A series of case studies of the 1990 and 1991 increases in the federal statutory minimum find no employment losses at all.[12]

With sufficiently large samples and lagged effects, a slightly more subtle picture emerges. Many economists have compared changes in aggregate employment of teenagers (16-19) and young adults (20-24) with changes in the statutory minimum, while attempting to control for possible confounding factors such as the number of young people, the overall level of wages, and the size of the military. Those studies report estimates of the elasticity of employment with respect to the minimum wage; i.e., the percentage change in overall employment with respect to a percentage change in the minimum. Thus, if the elasticity is 0.1, then a 10 percent increase in the minimum wage (as we had in 1991) will lower teenage employment by 1 percent. The estimates of this employment elasticity are small and relatively stable. The estimates range from 0.1 to 0.3 for teenagers and from 0.0 to 0.2 for young adults.[13] Extending the standard time-series analysis through 1986, Wellington (1991) obtains elasticities at the low end of the range; 0.076 for teenagers and 0.012 for young adults[14]

We prefer the most recent work by Neumark and Wascher (1992). They apply a time-series of cross-sections methodology. Exploiting state minima, they are able to include dummy variables for each time period and for each state. Furthermore, they consider, find important, and correct for lagged effects of the level of the minimum wage. Together, these changes result in a larger (in absolute value) elasticity estimate: 0.17 for both teenagers and young adults (defined as 16-24 year olds).[15] Finally, note that no recent study has attempted to estimate a minimum wage elasticity for workers over age 25.

2. The O'Neill and O'Neill Study

In their widely publicized study,[16] O'Neill and O'Neill (1993) make different assumptions in pursuing an alternative approach to estimating the employment effects of health care reform. Their approach yields job loss estimates of 3.1 million. They base their estimates on a series of industry-wide calculations, which we heuristically describe here (the actual computations are more disaggregated). First, they compute the change in payroll costs for each industry, based on the percentage of workers who are uninsured, whether the uninsured are full-time or part-time, whether the uninsured are single or in families, the estimated price of insurance, the degree of backward-shifting onto wages, and the current payroll. On average, they estimate that payroll costs for uninsured employees will rise by 28 percent.

Next, O'Neill and O'Neill translate this increase in labor costs into a percentage reduction in employment using an estimate of the *elasticity of employment with respect to labor costs*.[17] They assume an elasticity of 0.3, which they argue falls in the middle of the range of the relevant empirical estimates. Thus, the 28 percent increase in labor costs for the uninsured translates into an employment loss of approximately 8.4 percent (0.3 X 28%). Because their data indicate that approximately 32.6 percent of the nation's workforce will be affected by this mandate, they estimate that, overall, approximately 3 percent of all workers will lose their jobs (=32.6% X 8.4%). They disaggregate this figure according to whether the individual is currently covered under another family member's employer-based plan and by industry.[18]

Given our analysis of the effects of mandated health benefits, several methodological aspects of their approach appear to upwardly bias their estimates. In addition, their paper was written before the details of the President's plan were public. Differences between the plan they simulate and the President's proposal suggest several other reasons why their estimates are too high.

- *Choice and application of elasticities.* O'Neill and O'Neill compute the increase in payroll costs for an industry as a whole. Multiplying the percentage increase in labor costs by an employment elasticity, they compute the percentage of workers who will lose their jobs. However, mandated health benefits will not uniformly raise all employment costs as would be required for a strict application of the labor cost elasticities they use. Those who do not have insurance and therefore might lose their jobs are predominantly those individuals in the low-wage industries earning close to the minimum wage. Thus, we

prefer a strategy that draws on this analogy by applying the appropriate minimum wage elasticity estimate to the subpopulation of young adults.[19]

O'Neill and O'Neill argue that there is a downward bias in the elasticity estimates based on the federal minimum wage analogy. This bias arises because a firm cannot substitute capital for labor in the short-run, and so the long-run response will be more elastic than the short-run elasticity estimates suggested by the empirical literature.[20] Our preferred estimates (Neumark and Wascher, 1992) does allow for these lagged effects. Substituting these estimates to compute an intermediate-run response would cut O'Neill and O'Neill's predicted job loss by almost 50 percent.

- *Assumptions about labor's share of the burden.* O'Neill and O'Neill assume employers shift none of the cost back to employees earning less that $25,000, and only 50 percent of the cost to employees earning above that level. In their appendix, they do report estimates assuming costs were shifted for employees earning $15,000 or more, but only at a rate of 50 percent. As we noted in the previous section, the empirical evidence suggests that for workers earning above the minimum wage (plus the cost of the additional mandate), the employee bears nearly all of the increased cost. Assuming an 85-percent shift in costs would reduce their estimates by approximately 30 percent.

- *Plan costs.* Using data from a private benefits consulting firm, O'Neill and O'Neill assume a family plan costs $5,310 and an individual plan costs $2,160. These figures are approximately 25 percent higher than the more recent estimates by the Clinton administration of $1,800 and $4,200.[21]

- *No firm subsidies.* O'Neill and O'Neill have assumed no offsetting subsidies to small firms or employers of low-wage workers. The draft proposal calls for limits on employer contributions to between 3.5 and 7.9 percent of payroll. It is the explicit intention of such subsidies to minimize employment effects. For the industries they estimate will lose the most jobs, O'Neill and O'Neill assume payroll costs will increase between 4.0 and 16.4 percent, even after taking into account offsetting reductions in wages. These numbers clearly exceed the caps identified in the Clinton plan.

3. Better Estimates of Employment Effects

In this section, we generate preliminary estimates of the employment effect of the Health Security Act under a set of assumptions that we believe most closely reflects its likely effects. It is undoubtedly possible to generate more disaggregated estimates of the minimum wage elasticity and to apply them to disaggregated population counts. We do not pursue such an approach here. Rather, we provide an aggregate estimate of the jobs lost for the age group considered most at risk due to the imposition of a mandate in both the subsidized and unsubsidized cases.[22]

Table 1 presents estimates of the job loss under the Health Security Act under six scenarios: two sets of minimum wage elasticities (Wellington vs. Neumark and Wascher) and three sets of assumptions about the effect of the employment subsidies. We have already discussed the minimum wage elasticities above. Wellington's (1991) estimates update to the conventional time-series methodology for estimating the minimum wage. Neumark and Wascher (1992) implement what we believe is a superior econometric methodology yielding much larger minimum wage elasticities and therefore much larger employment effects.

Table 1

Job Loss from the Health Security Act

Elasticity	Wellington (1991)		Neumark and Wascher (1992)	
Cap on Employer Contributions	% Reduction in Employment	Jobs Lost (millions)	% Reduction in Employment	Jobs Lost (millions)
None	0.22%	0.251	1.48%	1.662
7.9%	0.07%	0.082	0.49%	0.545
3.5%	0.03%	0.036	0.22%	0.241

Even given the choice of minimum wage elasticity, there is an issue about how to extrapolate to the population over the age of 25. We define the "vulnerable" population as the set of workers who do not currently have employer provided health insurance and whose hourly wage is less than the sum of the minimum wage and the (unsubsidized) hourly cost of the health benefit (based on the worker's marital status and presence of children). Using Wave 5 of the 1990 Survey of Income and Program Participation (for the Spring of 1991), we compute that the vulnerable population constitutes approximately 24 .0 percent of all employees under age 25, but only about 6.3 percent of workers age 25 and over. Thus, it is not surprising that it is difficult to detect an effect of increasing the minimum wage on this group's aggregate employment. Nevertheless, workers aged 25-64 constitute over sixty of all vulnerable workers. The estimates in Table 1 extrapolate from the percentage of vulnerable workers aged 20-24 who lose their jobs to all vulnerable workers over age 25.[23]

The rows of the table vary the estimates to reflect different levels of government subsidies. The first row shows the effect of the legislation without the associated subsidies. From our data, it is not possible to exactly simulate the effects of the subsidies. There are two related problems. The first problem is that the Health Security Act provides subsidies on a sliding scale depending on the firms average per-employee payroll (and firm size)[24]. Our SIPP dataset does not include average per employee payroll of an employee's firm.

The second row corresponds to a 7.9 percent cap on employer contributions to health insurance, assuming the cap was takes a basis of individual earnings. This estimate of the number of workers who will lose their jobs is both overstated and understated because of this assumption. It is overstated, because some firms (those with under 50 employees and low average per-employee personnel costs; e.g. a firm which is all minimum wage workers) will

receive subsidies equivalent to a lower cap[25] . It is understated because some low wage workers are employed by firms with high average per employee personnel costs (e.g. the mail clerk in a small law firm); thus, these employers will not receive a subsidy.

The third row corresponds to a 3.5 percent cap on employer contributions to health insurance. This corresponds to the outcome if all employees worked in small firms with low average per employee personnel costs. This estimate provides a lower bound because most firms will face a cap higher than 3.5 percent. By how much it is too low, is however, unclear.

The legislation provides strong incentives to reorganize employment such that low wage workers work for small firms (under 50 employees) with low average per-employee personnel costs. In the extreme case, the magnitude of the subsidy is over $3,000 per employee. A low-wage worker in a high wage firm is ineligible for any subsidies. The cost to the firm for his health insurance is thus the full 80 percent of the premium ($2,479 for a couple with children, $1,546 for a single individual). However, if the firm contracts out the work to a firm eligible for the 3.5 percent cap, then the cost to the firm for his health insurance is capped at $309 (3.5% of $8840). Employment costs fall by over $2,000 for a married person with children, and over $1,200 for a single individual without children. These subsidies are respectively 25 and 14 percent of payroll. Clearly this large differential in the subsidy creates strong incentives for firms to outsource their relatively unskilled labor-intensive tasks in order to appropriate some of these government subsidies.

The possibility of this reorganization is the second problem with choosing which of the rows of the table to use to generate an estimate. The more such reorganization occurs, the closer the employment effect will be to the third row (and the higher will be the cost in the form of subsidies). Phasing-out the subsidies or enacting regulations to discourage such reorganization would have the effect of lowering government costs but also raising employment losses.

Although there are many uncertainties involved in the calculations, we have greater confidence in the Neumark and Wascher methodology than in those involved in other estimates in the literature. We believe that the 7.9 percent cap is probably a good estimate of the net effect of the offsetting biases (some low wage employees in high wage firms will be ineligible for subsidies; some workers are, or will find themselves after the reform, in firms eligible for caps below 7.9 percent of payroll). Under these assumptions, we estimate that the Health Security Act will yield a decline in employment due to the burden of the required premium of about half a percent of total employment (of 18 to 64 year olds). This estimate is only one-sixth of the estimate of O'Neill and O'Neill using a different methodology which we discussed earlier.

4. Conclusion

In this white paper, we have reviewed the theory behind estimating employment effects of health care reform, critiqued a widely cited set of estimates, and provided alternative estimates of the job loss associated with a mandate. Our best estimate is that job

losses will total about half of one percent of employment. This estimate is about a sixth of the estimates of O'Neill and O'Neill. Ultimately, the magnitude of these employment effects will depend on the details of the final health care reform legislation.

Our estimates have only considered the direct employment effects due to job losses as employers react to increases in the minimum legal compensation. There are several other possible employment effects which we have not considered here. First, an explicit goal of the Health Security Act is to reorganize the health sector to yield better health care at lower cost to more Americans. In as much as firms see their health insurance bills go down (either due to lower cost of health care itself or due to lower loading factors), firms may increase employment. Similarly, the HSA's guaranteed health coverage should alleviate problems of job-lock and welfare lock. These changes may also increase employment.

On the other side, some of the effects of the plan may yield lower employment. First today some people work in order to gain health insurance. Under the plan, health insurance will be available even to non-workers. This effect is likely to be most important for older workers considering early retirement. Second, in as much as firms pass the cost of health insurance on to workers in the form of lower wages, some people may choose not to work, the cash wage per hour worked has declined. This effect is likely to be most salient among secondary workers.

Finally, it is possible that the shift of expenditures into or out of the health sector (depending on the net effect of the reform on employment in the health sector) may cause a change in total employment. To a first order, however, the dollars spent in the health sector are dollars not spent in some other sector, so net employment effects will be a function of the relative employment in the health sector for a dollar of expenditure. These effects are likely to be small.

Though our employment effect estimates are lower than many other estimates, this does not imply that health care reform will increase health insurance coverage at minimal cost (beyond the explicit on-budget expenditures). Our estimates are low specifically because we expect that firms will successfully pass on the cost of their share of the health insurance premium to their employees in the form of lower wages. Real wages for low skilled workers have fallen considerably over the last two decades, so the assumption of downward flexibility of wages seems plausible. Thus, the currently uninsured will pay much of the cost of the expansion of health insurance. This gives this apparently progressive legislation a significant regressive component.

The obvious way to mitigate the regressive nature of employer-based health insurance finance is to provide government subsidies to low-wage workers. Doing so will mitigate the negative employment effects and the fall in wages. However, doing so is also expensive. The higher the subsidy, the higher the budgetary expense. An alternative is to subsidize only firms that do not offer health insurance (and then possibly only their low-wage workers). However, this creates large incentives for firms to rearrange production to take advantage of the subsidies.

In summary, our best estimates of job loss are much lower than many of those which have been cited in the debate over the Health Security Act. The magnitude of these changes involved in a major reorganization of a major sector of the economy lead us to treat our estimates as informed guesses; with such a major reform unexpected consequences seem possible, if not likely. Nevertheless, our best estimate is that job losses due directly to increased costs to employers will be under one half of one percent of total employment. Plausible alternative estimates are much lower. We conclude that direct job loss need not be a major consideration in the evaluation of the President's plan. However, these low estimates of job loss are a direct result of our assumption that most of the cost of the mandated health benefit, including what is nominally the employer's share, will be shifted back to employees in the form of lower wages.

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Endnotes

[1]This testimony draws on our ongoing research at RAND. It does not necessarily represent the position of RAND or its sponsors.

[2]Personal communication with staff at the Council of Economic Advisers indicates that the estimated premiums are $1,800 for single individuals, $3,600 for married couples, $3,700 for single-parent families, and $4,200 for two-parent families.

[3]Average earnings come from the Bureau of Labor Statistics, *Employment and Wages Annual Averages, 1991*, Bulletin 2419, United States Department of Labor, January 1993. The computations for employer contributions as a percentage of payroll are as follows: A single individual working at the minimum wage earns $8,800 annually. Under the mandate, the employer contributes 80% of the cost of insurance ($1,800). Thus, the employer contributes 16 percent of earnings towards health insurance (80% x $1,800/$8,800). For a worker in a two-parent family, the contribution is 38 percent of earnings (80% x $4,200/$8,800).

[4]Subsidies may limit employer contributions to between 3.5 and 7.9 percent of payroll.

[5]The O'Neill and O'Neill report has been cited by the Boston Globe (September 8), Christian Science Monitor (September 24), Newsweek (August 30), New York Times (August 30, September 28, and September 30), San Diego Union-Tribune (September 1 and September 22), Wall Street Journal (August 20), and the Washington Times (August 31).

[6]Over the last decade, the real earnings of low-wage earners have proven to be quite flexible downward. Karoly and Klerman (1993) estimate real earnings for low-wage workers have fallen 15 percent.

[7]Various problems with Gruber (1992) limit its applicability to the more general mandated benefits case. For instance, Gruber (1992) finds that a $1 rise in the cost of maternity care on average leads to a .22 percent reduction in the probability of employment. Extrapolating to the case of a mandate that increased costs by only $250, his results imply a 50-percent reduction in the probability of employment. This figure is implausibly high.

[8]Gruber's work revises earlier work on the effects of payroll taxes on wages. Currently, both the employer and the employee nominally contribute 6.2 percent of taxable earnings to Social Security and 1.45 percent to Medicare. However, many economists argue that employees bear all the burden of both the employer and the employee's share in the form of lower wages (Brittain, 1971). Some researchers have tried to exploit slight annual changes in these tax rates, and larger differences across countries, to estimate the extent of backward-shifting of employer contributions. Not surprisingly, the empirical evidence on this question is mixed. Brittain (1971) and Vroman (1974) both use cross-national comparisons to demonstrate that labor bears 100

percent of the burden of the tax. However, Hamermesh (1979) estimates that only 33 percent of the tax is shifted for white males. Because of the disparity in these estimates, we cannot infer much from this literature that is relevant to the debate on mandated benefits. In conjunction with the above analyses of narrower mandates, we tentatively conclude that higher wage employees bear much of the burden of a mandate in the form of lower wages.

[9]For instance, 27.4 percent of individuals 18 to 24 years old are uninsured, whereas only 10.5 percent of individuals 45 to 64 years old are without coverage (Ries, 1991).

[10]Using data from the 1987 National Medical Expenditures Survey, Hahn and Lefkowitz (1992) compute mean health care expenditures for the entire United States population, as well as for the subpopulation of 18- to 44-year-olds. For the entire population, the mean annual expense for health care is $1,521 (computed as the product of two figures in Table 1 of their findings: the percent of persons with expense and the mean annual total expense per person with expense). For 18- to 44-year-olds, the mean expense is $1,019. For those under 65, the mean expense is $1,150. Thus, 18- to 44-year-olds have mean expenses that are approximately 33 percent lower than the national average and 11 percent of the average for those under 65.

[11]The President's plan further subsidizes the rich at the expense of the poor. By financing the benefits expansion through cigarette taxes rather than the taxation of premium contributions, the President implicitly taxes low-wage earners (who may have a greater propensity to smoke) at the expense of high-wage earners (who may have a greater propensity to purchase expensive health care plans).

[12] In a study of fast-food restaurants in Texas, Katz and Krueger (1992) find no employment response to the 1990 and 1991 increases in the minimum wage. Card (1992a) compares the changes in employment in states with high and low wages around the increases in the federal minimum in 1990 and 1991. He also finds no evidence of a regular impact on employment. Card (1992b) analyzes employment responses to changes in California's minimum wage in 1988 for the retail industry, which employs almost 50 percent of the minimum and subminimum workers. By comparing retail trade in California with other states that did not change their minimum, he also finds no employment effects. From these case studies it is clear that firms reactions to the minimum are not simply to fire all (or even a large share of) workers with wages between the old and the new statutory minimum.

[13]Brown, Gilroy, and Kohen (1982) and Brown, Gilroy, and Kohen (1983) are the standard references on the effects of the minimum wage. Their two papers survey the previous research, provide updated estimates of employment elasticities with respect to changes in the minimum (as of the early 1980s) and explore the sensitivity of the results to several estimation decisions. Following earlier literature, they estimate the elasticity of teenage employment with respect to the minimum wage, where an elasticity of x implies: If the minimum wage rises by 1 percent, teenage employment falls by x percent. Also following the literature, they estimate this elasticity using time-series regressions on aggregate employment counts since the late 1950s. Thus, the parameter of interest is the percentage change in employment of teenagers or young adults with respect to a percentage change in the minimum wage. Since over most of the post-war period the minimum wage was relatively constant, the estimates are necessarily imprecise. Still, Brown, Gilroy and Kohen (1983) find a small but significant employment elasticity. According to their estimates, a 10-percent increase in the minimum wage lowers teenage employment from 1 to 3 percent (an elasticity in the range of 0.1-0.3).

In the late 1970s and 1980s, the nominal wage remained fixed, but substantial inflation eroded the real minimum's value. This natural experiment provided substantial variation in the real minimum wage, prompting speculation that a larger employment elasticity (more in line with the stark predictions of economic theory) could be found. Brown (1988) provided some back-of-the-envelope calculations suggesting that a large elasticity was unlikely to emerge from extending the time series. Klerman (1992) and Wellington (1989) capitalize on this natural variation in the real minimum over the 1980s to update these estimates. They find even lower elasticities than Brown, Gilroy and Kohen—an elasticity of less than 0.1 for teenagers and approximately zero for young adults. This elasticity implies only a 1-percent decline in teen employment due to a 10-percent increase in the minimum wage.

Neumark and Wascher (1992), exploiting variation in state minimum wages from 1973-1989, also estimate a 1- to 2-percent decline in teenage employment due to a 10-percent increase in the minimum. Thus, it seems safe to conclude, as Brown, Gilroy, and Kohen (1983) do earlier, that there is ". . little evidence that the effect of the minimum wage on the employment of white, male, or female, teens differed appreciably from the 1 percent estimate."

[14]These elasticities are her base case plus the enrollment to population ratio. Her base case (without the enrollment to population ratio) is not significantly different from zero. Even including the enrollment to population ratio, the estimate for young adults is not significantly different from zero.

[15]Specifically, we prefer Neumark and Wascher's (1992) specifications (2) and (6) from Table 5.

[16]The study has been cited in the Wall Street Journal (August 20), New York Times (August 30), Newsweek (August 30), Boston Globe (September 8), Washington Times (August 31), San Diego Union-Tribune (September 1), and the results have been entered into the Congressional Record (September 22).

[17]O'Neill and O'Neill (1993) base their estimates on the following calculation for those individuals affected by the mandates:

$$\begin{pmatrix}\%\text{ change in}\\ \text{employment}\end{pmatrix} = \begin{pmatrix}\%\text{ change in}\\ \text{employment}\\ \hline \%\text{ change in}\\ \text{labor costs}\end{pmatrix} \times \begin{pmatrix}\%\text{ change in}\\ \text{labor costs}\end{pmatrix}$$

The first quantity on the right-hand side is the elasticity of demand for labor; thus, the relationship may be written as:

$$\begin{pmatrix}\%\text{ change in}\\ \text{employment}\end{pmatrix} = \begin{pmatrix}\text{elasticity of}\\ \text{employment}\end{pmatrix} \times \begin{pmatrix}\%\text{ change in}\\ \text{labor costs}\end{pmatrix}$$

By multiplying this elasticity by the percentage change in labor costs, they compute the relative change in employment.

[18]O'Neill and O'Neill identify seven industries characterized by relatively low wages or a large fraction of uninsured that will be extremely adversely affected by the mandates: eating and drinking, private household services, agriculture, repair services, personal services, other retailing, and construction.

[19]Ideally, we would like to know how the minimum wage legislation affects all segments of the age distribution, not just teenagers and young adults. However, for most segments of the wage distribution, the mandate will have little effect on employment for those earning greater than the sum of the minimum wage and the hourly cost of the mandate. Thus, older workers will be relatively unaffected by a mandate due to the

strong link between age and earnings. For exactly this reason, researchers examining the minimum wage do not estimate elasticities for older segments of the population, since the law is not binding for this group. With regard to a health insurance mandate, older individuals are far more likely to have health care and higher wages. Thus, a health insurance mandate will not significantly affect employment for these individuals. Therefore, the appropriate elasticity for older individuals should be very close to zero, or at the very least bounded by the minimum wage elasticity.

[20]O'Neill and O'Neill also dismiss the case-study evidence showing elasticities much closer to zero, because, in their view, it considers only short-run changes, because it uses data from three national chains of restaurants that may be atypical in a number of ways, and because the results do not include the effect of the minimum on firm entry and exit. This point is made by Neumark and Wascher (1992), whose methodology is designed to accommodate these effects.

[21]A nationwide survey of employers indicates the average annual premium was $1,728 for an individual and $4,260 for family coverage (Sullivan et al., 1992). Assuming an employer mandate did nothing to reduce premiums, O'Neill and O'Neill's figures still exceed the average nationwide cost by approximately 25 percent.

[22]Most investigations of the effect of the minimum wage estimate elasticities for teenagers (16-19) and young adults (20-24) only. These subpopulations constitute the majority of individuals who are most likely to be affected by changes in the minimum wage. If a researcher were to estimate an employment elasticity with respect to the minimum wage for individuals over 25, this elasticity would be very close to zero. Most workers in this age bracket earn more than the minimum, and so the legislation is non-binding for this age group. Analogously, the majority of individuals over the age of 35 already have health insurance or their earnings are sufficiently high that they are at not at risk for losing their jobs. Thus, we look for employment effects only in the subpopulation under the age of 35.

[23]The estimates are based on employment counts for Calendar Year 1992 from the Current Population Survey (the Household Data) as reported in *Employment and Earnings*, January 1993: 3.3 million workers aged 18-19, 12.1 million workers aged 20-24, and 96.6 million workers aged 25-64. The number of vulnerable workers are 1.5 million aged 18-19, 2.2 million aged 20-24, and 6.0 million aged 25-64. As is noted in the text these numbers are computed based on the percentages of vulnerable workers in the SIPP (0.440, 0.185, and 0.063) multiplied times the 1992 employment counts.

[24]Only firms with 50 employees or less are eligible for a subsidy. The subsidy rate varies with average payroll, as indicated in the following table:

Subsidy as a Function of Average Wage

Average Wage per Full-Time Equivalent	Subsidy
$12,000 or less	3.5%
$12,001 to $15,000	3.8%
$15,001 to $18,000	4.4%
$18,001 to $21,000	5.5%
$21,001 to $24,000	6.5%
$24,001 or more	7.9%

[25]In executing the simulations, this cap merely requires that we reestimate the employment effects assuming the increase in labor costs is the minimum of the subsidy or our estimate of the increase in labor costs in the absence of subsidies.

The CHAIRMAN. Thank you very much.

I almost feel like we are back at a NAFTA hearing in terms of what is going to be lost and what is going to be gained in regard to jobs on this issue.

Dr. Lewin, in terms of the CPI, what are the health care costs in Hawaii versus the CPI?

Dr. LEWIN. Health care costs have risen more rapidly than CPI, as they have elsewhere. But the differential between the mainland costs and CPI in Hawaii have been less catastrophic for our small businesses. Our CPI costs have certainly increased of late very, very much in terms of real estate costs, for one thing, but then all other costs—fuel, food, etc.

If you compare health care and its relationship to total cost, it looks like a bargain compared to CPI costs in Hawaii——

The CHAIRMAN. Just to be clear, we are talking about between 2.5 and 3 percent for health care costs—prescription drugs are a little higher—greater than the CPI.

Dr. LEWIN. That is right.

The CHAIRMAN. And I am just wondering what the experience has been in Hawaii, say in the last 5 years.

Dr. LEWIN. Hawaii has had about a 10 percent rate of increase in health care costs over the last few years. CPI in the last 2 or 3 years has been less than that as a percent of increase. But Hawaii had enormous leaps in CPI costs in the 1970's and 1980's, as a result of labor—

The CHAIRMAN. So it is difficult.

Dr. LEWIN. It is difficult to make the comparison, but I can give you the bottom line. CPI right now is 38 to 40 percent higher than the U.S. Health care costs are 35 percent lower than the U.S. average.

The CHAIRMAN. Mr. Pauly, given the experience in Hawaii—and I will ask Mr. Klerman to respond as well—and the way that it has worked out in terms of employment and in terms of the types of people who have been employed, how should we look at the way that you calculate the impact on jobs versus the practical experience that we have seen in Hawaii over a considerable period of time? Where is the disconnect?

Mr. PAULY. It is the usual problem that economists have—other things are not necessarily equal, and other circumstances, including growth in the tourist industry and so forth, have affected Hawaii more than other parts of the country. So there is really no way to tell with one observation, a sample of one, what is a generalizable conclusion.

The CHAIRMAN. But the disparity is so dramatic in terms of the impact on jobs and the total number of people who will be adversely impacted versus some of the other economists, generally speaking. I was just trying to better understand how you reached those conclusions.

Mr. PAULY. I think the disparity is not actually all that substantial. The difference is between one-half of one percent of employment and, in my calculations, approximately 2 percent.

The CHAIRMAN. Well, that is a pretty big number in terms of the millions of people that would be affected.

Mr. PAULY. It will surely matter to those individuals. I think the answer is—for reasons that I discuss in my statement—that I believe the studies of the minimum wage are not particularly relevant to understanding what is likely to happen with this kind of mandated additional benefit of the order of magnitude—$1.67 per hour for some workers, as I discuss—and adding the cost of a benefit which, even under the administration's proposal, will increase in cost each year in line with the CPI.

The reason why we think the minimum wage empirical studies seem to clash with the textbook—I guess economists do not want to believe the textbook is wrong—at least one of the explanations is that employers rationally figure that inflation will erode a 25 to 50 percent increase in the minimum wage fairly quickly.

But the thing about health care costs, with the possible exception of Hawaii—and maybe this is an answer—is that historically, inflation has not eroded their value; in fact, inflation has actually added to their cost.

So in my calculations, I tried to set an upper bound estimate of what the worst consequence could be.

The CHAIRMAN. You are saying that it increases by $1.67 an hour?

Mr. PAULY. I think that is what Jacob said as well. If you think of a minimum wage worker, working for a firm with high average wages, buying family coverage.

Mr. KLERMAN. That sounds about right; something like $1,700 for an individual, and it is about $2,500 for a family, and there are 2,000 hours. So $1.20, $1.60—it depends on exactly——

Mr. PAULY. I was using $4,200 for the family premium, for husband, wife, and children.

The CHAIRMAN. Dr. Lewin.

Dr. LEWIN. Senator, I appreciate the dilemma that economists have when they are looking at the way things have evolved on the mainland and the complexity of all the issues. The tendency is that we tend to project our present status into the future and not envision what it is like to be in an insurance reform environment, with a standard benefit package, where every insurer or accountable health plan in the State is making a quote on the same exact product, with all the same features built into it, and there is a tremendous desire to undercut the price of the competitors to bring the consumers in. So that there is a degree of real competition in a marketplace on the same product and with insurance reform factors built in to eliminate the pre-existing exclusions and all that stuff.

What happens then is you end up with overall lower costs of coverage and more efficient coverage. And when you do that, you are not giving businesses this lousy situation of projecting the present bad environment for businesses, and therefore you are going to have—yes, if you project the present environment, you are going to lose jobs, the low-wage employers are going to be adversely affected, etc. That just has not happened in Hawaii because of the level playing field.

The CHAIRMAN. Did you include the subsidies, Mr. Pauly, in your calculation?

Mr. PAULY. Yes. That was intended to take into account what the net increase would be in costs.

The CHAIRMAN. So I guess it is approximately $167 billion. That is what the administration has talked about. You have taken that into consideration as well in terms of your projections?

Mr. PAULY. I use the word "conjecture," which is I think appropriate for an economist to use here, but the calculation was based on looking at the number of workers who currently do not have health insurance—who have jobs paying at or very near the minimum wage, where any mandated increase in the cost of their compensation, because it cannot be offset by a lower cash wage, would cause unemployment to occur.

I understand Secretary Reich has been contemplating or at least discussing the possibility that some of the minimum wage increase might actually be adjusted for increase in the cost of mandated benefits. That is something I very much favor.

The CHAIRMAN. Mr. Klerman, what is your reaction in terms of the overall figures? How do you come up with those different results?

Mr. KLERMAN. I guess I would view my reading of the situation as broadly consistent with Dr. Lewin's report about what has happened in Hawaii. My bottom line was one-half of one percent. That would be something you would not be able to see in a State like Hawaii where there are lots of other things happening, and it confirms my bottom line, which is that there are lots of things to consider about health care reform, but one of them is not job loss.

I am a little bit disturbed by the difference in my final, bottom line numbers, between my analysis and Dr. Pauly's. Dr. Pauly is a well-respected health economist, and I guess in the hall afterward, we will talk about why our numbers differ exactly. But I can give you a couple of hypotheses that might help.

I would like to start by saying that I have not seen the details of Dr. Pauly's analysis, but I am reassured that the basic assumptions he seems to be making are basically similar, that most of the costs of the health insurance premiums will be borne by the individuals, by the workers, and that means their employers will go down.

But I disagree with Dr. Pauly in his assessment that this is really going to be a very large increase in the costs, even in the absence of subsidies. In 1990 and 1991, we raised the minimum wage in the United States from $3.35 an hour to $4.25 an hour over 2 years. That was 90 cents. That is in the same order of magnitude as the increase in cost that we are talking about with this plan, even in the absence of subsidies, and it is off by 50 percent, say, depending exactly on how you calculate. But to say, as many people have, that the order of magnitude of changes and costs are totally out of range of what we are used to I think is a misnomer.

The second thing is that inasmuch as I can figure out how Dr. Pauly does his analysis, I have a couple of comments. He figures that everyone with earnings below $6.50 will be vulnerable. We went through and did the calculations exactly based on the costs per individual that were given to us by the President about costs based on family status, and we get an estimate of the vulnerable population which is only about two-thirds the size of Dr. Pauly's.

Also, our bottom line number is that of those people, about 15 percent of the vulnerables would lose their jobs. That is the number that we get if we ignore a subsidy. If you put those two numbers together, Dr. Pauly's number is pretty close to ours in the absence of subsidies, but the President's plan was specifically crafted to minimize job losses in the form of offering subsidies, and that should mean that the numbers will get lower.

We are personally unhappy, or not done, with our analysis of exactly how many people would be eligible for which types of subsidies, and those analyses are complicated by the fact that it is hard to figure out how many people will take advantage of reorganizing their firms, breaking up firms, as Dr. Pauly said. The more that that happens, the smaller will be the health effects. But as of now, our best guess is that the average premium will be about 8 percent, sort of the maximum subsidy, and in that case we get numbers that are on the order of one-fifth lower than Dr. Pauly's.

The other thing to note is that we believe that the minimum wage analogy is correct, but it is also true that the numbers we are using for the effects of minimum wage are among the largest in the literature. As an econometrician, I personally am happy with those larger numbers, but it would be easy to pick a smaller set of numbers, based on slightly more conventional methodologies, and they would give you estimates of employment effects that would be—I think there are six of the ones that are in our testimony. So I would think that if anything, my numbers are too high, not too low.

The CHAIRMAN. Thank you.

Senator Jeffords.

Senator JEFFORDS. Thank you, Mr. Chairman.

Dr. Lewin, could you explain to me a little more how the Hawaiian system works as far as universality goes? If I am unemployed, how am I covered?

Dr. LEWIN. If you are unemployed, and you have no other means, there is no one in your family who is working—if you are unemployed, and you have another family member working, which is probably the case, then you will be covered through that family member. Let us say you have no other working family member who would be able to extend family coverage to you. Then you would be covered by a program called the State health insurance program, funded by general funds of the State of Hawaii. It provides health insurance for these individuals and for their families if needed at a shared cost between the State and the individual. The State picks up the entire premium. The program is free, in essence, if you are at 100 percent of Federal poverty or less in terms of whatever sources of income you have as a family, and it goes on a sliding scale up to 300 percent of poverty.

So the unemployed, the part-time employed, the self-employed on commissions, and students are covered through the State health insurance program. Anyone who is not covered by Medicaid, Medicare, or by virtue of employment, veterans, or some other full coverage, is eligible for SHIP.

Now, at the moment, as we talk, Hawaii is preparing to fold SHIP, this gap insurance program, with Medicaid and general assistance into one public sector program with the same benefit pack-

age as the work force program, meaning that everyone under 65 in Hawaii will be covered in one basic benefit package. One portion of it will be publicly funded, and one will be funded by employers and employees. But it will all be the same basic program. We are in the midst of that conversion. We have obtained a waiver for the Medicaid portion of it from HCFA, so we are converting it. That is how everybody is covered.

The only people who would not be covered in Hawaii—of course, we have 8 million visitors a year, and many tourists come in and cost-shift to us because some of them do not have coverage. We also have all the Pacific Island American-affiliated nations who come to Hawaii for their health care, because it is the only place they can get it. They come, and they basically cannot afford to pay, and we pay the bill. We also have cost-shifting from a very large number of undocumented aliens who come from the Philippines, from Asia and other ways into Hawaii and who are part of our population.

So we still have that cost-shifting, but the main cost-shifting in Hawaii is from Medicare and Medicaid.

Senator JEFFORDS. Mr. Pauly, assuming you want universality, how would you provide funding?

Mr. PAULY. Well, I think there are really two issues. One is the vehicle and the other is the pattern of subsidies. The main problem, as I have emphasized, in the pattern of subsidies embodied in the administration's proposal is that it is very stingy. It imposes the lion's share of the cost of insurance coverage on low and middle-income families, essentially by taking it out of their money wages.

So the proposals that I and my colleagues have looked at have generally involved a more progressive scheme of tax credits that would extend subsidies up to perhaps 300 percent of the poverty line. So that is an issue of how to make it equitable.

The issue of how to make it efficient, I think the easiest approach there is to simply require individuals to obtain adequate coverage and let them choose what is the best way they want to obtain it. I think most people will find, partly because it is the way things are, and partly because it is usually most efficient, they will try to arrange it through their employment relationship. But for others, it may be that that is not the best way to arrange coverage, that other sorts of groupings may work better, or purchasing directly as individuals, particularly if there is, as we propose a fallback Government contract that would be an insurer of last resort.

Senator JEFFORDS. Would those tax credits be in the form of vouchers?

Mr. PAULY. They would be in the form of a voucher for somebody who owes no additional tax and would be in the form of an offset against income taxes owed for people who owed income tax.

Senator JEFFORDS. Thank you.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman.

Mr. Pauly, I think you were quoted in the winter 1990 issue of Financing Health Care Quarterly Review of Economics and Business by one of my friends in Minnesota who admires you greatly, Brian Dowd, as saying—I use this in reference to a question of Dr. Tyson earlier—"The problem is not total spending, particularly in

the private sector. The problem is market failure, primarily in the form of health insurance and health care services, purchased with subsidized dollars at noncompetitive prices."

The question I want to ask you as a background is how wise are we as a nation to go to universal coverage before we are convinced that we know how to change the system, either the way they have predicated change in Hawaii or in some other way?

Mr. PAULY. Well, I think the universal coverage in terms of real cost is not very substantial, for exactly the reasons that Ms. Tyson mentioned, that for the most part, people are already receiving services, so the extra cost is really just a transfer from someone else, from one pocket to the other.

The real issue is, as I said, how equitably are we going to move toward universal coverage, and somewhat surprisingly, the administration's proposal is highly regressive on that score.

And then the issue is whether we need to add, or whether it is possible to avoid adding, a set of additional distortions and restrictions that might cause people to fail to be able to get the coverage in the way which is really best for them.

So I would not lie awake nights worrying about the impact of universal coverage on cost. I would worry about the impact of the tax subsidy that I benefit from substantially, causing me not to be as economical a consumer of health care as I really ought to be.

Senator DURENBERGER. Those are difficult issues to get across to people. It is pretty simple, I would guess, to say that we are gong to guarantee everybody a health security card and we are going to find some way to pay for that. In the case of the administration, they pay for that by this sort of elaborate interchange of savings and expenditures between employers at various levels, plus a sin tax.

But there is still this doubt out there in America that anything invented in Washington, whether it is predicated on Hawaii, Canada, or something else, is really reliably going to do anything about the cost of the individual American.

But what I hear you saying is that you could probably construct a minimum benefit comprehensive package—you could put together some preventive services and the catastrophic—and we could buy that, or some part, for the 36 or 37 million uninsured, or we could hook it into employment so that the employer would pay part of it. We would use public funds up to 100 percent of poverty or whatever it is, and then use some other system after that. And you are saying that except for the transfer of funds, which is ongoing, between Hawaii and Los Angeles or between Minnesota and Los Angeles, or between conservative practitioners or small businesses and large, the ones that have the big tax subsidies, except for the fact of the inequities in the system, the overall cost to the country would not be that great to go to universal coverage. Is that right?

Mr. PAULY. Yes.

Senator DURENBERGER. John, let me ask you about——

The CHAIRMAN. Would the Senator yield?

Senator DURENBERGER. Yes.

The CHAIRMAN. Do the other panel members agree with that comment?

Mr. KLERMAN. I agree with what Mr. Pauly said and what the Senator is going toward. As I said in my testimony, the administration's plan has some regressive aspects to it, and alternatively, one could think about plans that do not go through the employment relation. But I am not convinced that the negative effects of the employment relation are as drastic as Mr. Pauly thinks right now.

The CHAIRMAN. I think the question was on the cost in terms of covering the uninsured, and I thought Mr. Pauly said that given the reality that everyone does get covered, that it would not be significant—but I do not want to put words in your mouth.

Mr. PAULY. Yes.

The CHAIRMAN. And on that particular question, I would like to hear from the others.

Dr. LEWIN. We found that to be the case. If you really have the full effects of an employer mandate, then the people remaining are an upwardly mobile group of relatively healthy people, because you bring in most of the chronically ill with the employer mandate and their dependents, if the dependents are in.

So that we found with our gap group—it was a tremendous risk that Hawaii took when we put the SHIP program out there, because the fear was that we would have this huge mass of chronically ill, uninsured people. We found out they are an upwardly mobile group. And what we have discovered is that the same group of people in the gap would quit their part-time jobs and go back to Medicaid coverage if somebody in their family got sick. And in fact, with the advent of the SHIP program, they kept their jobs and moved on to full employment and then went off the program, the subsidy the State had to provide, so it has been an economic benefit both in terms of jobs and upward mobility of that in-between group.

Senator DURENBERGER. Dr. Lewin, help me understand. The first part is the problem that you and I both suffer from, which is that people will say Hawaii and Minnesota are different. I have just been through the experience you may have had yesterday, of arguing with HCFA over tougher risk contracts, because you are getting penalized the same way I am getting penalized in Minnesota, for efficiencies.

Dr. LEWIN. Yes, absolutely.

Senator DURENBERGER. But they are willing to give New York a 15 percent bump and so on.

Dr. LEWIN. Yes.

Senator DURENBERGER. If you can in 2 minutes—and you have probably practiced this—demonstrate that it is not the weather and things like that that make Hawaii different. I happen to think it is the weather in Minnesota that makes us different, because everybody has to have a common enemy in order to do good, and we have a common enemy in the weather. [Laughter.] But you know, we hear that all the time, that somehow Minnesota is different, and you cannot replicate it somewhere else. But then go from that into principally the role that the insurance plans play in all of this. Are they just traditional insurance, or have they taken on some other aspects?

Dr. LEWIN. No, they are not. As far as the weather, genetics, and life style, you know, the weather, you have to look at as kind of

nebulous factor, but you really need to look at morbidity and mortality risk factors in the population and behaviors of the population.

Hawaii, for example, has a higher rate of essential hypertension than the United States, a higher rate of elevated cholesterol. In terms of behaviors, Hawaii consumes more alcohol per capita than most States. We are very heavy in terms of excessive alcohol, drinking and driving, fat consumption, salt consumption, and surprisingly—here is one with the weather—Hawaii is more sedentary than the national average. We have the greatest weather, but what is happening is that people are working two jobs and then a part-time job to try to make their lives work, and the stress in families is very, very high.

So CDC does relationships of States, and although we come out really great—in fact, with Minnesota, the best in terms of health status outcomes, when you start out with risk factors, population life styles, and premature morbidity and mortality risks, we look like we are going to head for all kinds of problems. Our system intervenes.

Let me take breast cancer very briefly. We have one of the highest rates of breast cancer among Caucasian women in Hawaii of all 50 States. We also have the lowest death rate from breast cancer of all 50 States. How does this add up? We are diagnosing it more effectively, and we are treating it earlier, at lower cost.

Hawaii shifts toward primary care because of universal access. Universal access saves money if it is designed right and works right, and that is part of the way we get to the other end.

Insurance in Hawaii has behaved—your second question—because it has had to take on the burden and risk of all of that chronic disease population. In other States, insurance companies have been able to eliminate that risk by rejection or ejection, or even geographic kinds of patterns of bringing in their consumers so that they avoided the risk. And risk avoidance has been the whole process. In Hawaii, since they could not do that, our insurance companies frankly have learned to behave differently. They have been much more aggressive at utilization controls, much more aggressive at holding down costs. Ninety percent of Hawaii's doctors participate, for example, fully with Blue Cross, and they accept no additional payment other than what Blue Cross assigns them. That is nearly miraculous considering that Blue Cross, then, is the cost controller that sets almost a global rate for services and methods.

Senator DURENBERGER. Who has got what percentage of the business? Do you have basically the same insurance companies all the time?

Dr. LEWIN. No, we do not.

Senator DURENBERGER. Does anybody new ever show up on the scene and become successful?

Dr. LEWIN. We do have new ones, but in 1974 when the law was passed, we had mostly the commercials—the Aetna, Prudential, Signa type group. It totally changed in 1974, where Blue Cross and Kaiser started moving up because they community-rated. The commercials refused to community-rate, and so they dropped out of the employment market in Hawaii.

Senator DURENBERGER. Did they community-rate within their own system so that the price might be different to different people, depending on what plan you went into?

Dr. LEWIN. No. The plan is statewide. In essence, what we have is kind of an informal alliance for all businesses under 100 employees. There is no structure to it, but all businesses under 100 are in one huge risk pool, and in that risk pool, insurance companies quote a statewide rate for their product. Again, recognize they are quoting a statewide rate for the same product, so Blue Cross, Island Care, HDS, Queens Health Plan, and Kaiser Permanente all quote their rates; and then, frankly, if their rates vary much, consumers do shift from company to company on an annual basis. There is real competition around rates.

Now, it is true that Blue Cross has almost half of the total market of employees, although they have it divided among competitive plans in their own organization. They have an HMO, a PPO, a fee-for-service. But people always talk about when a prepaid, capitated health care system like Hawaii's would come into being, then automatically, everyone would be forced into HMOs, fee-for-service disappears, etc. Hawaii, 20 years later, still has two-thirds of its population in fee-for-service. We have a great HMO in Kaiser Permanente, one of the most popular and most effective of all the Kaiser regions, but people still choose fee-for-service.

The thing is that fee-for-service in Hawaii is more managed than any fee-for-service in the country. It is managed because the companies that provide it in essence have a fixed budget, and they have all the chronic disease, or most of it, in their populations.

Senator DURENBERGER. I have a series of questions, and maybe I could just submit them. I think one of the things that would be helpful in terms of—certainly, whatever you might want to say and add to the record relative to Medicare, Medicaid, the tax subsidy—the three big public subsidies that in one way or another may end up distorting the market, but particularly Medicare and Medicaid, because that is where you point out you are getting a huge cost shift and so forth.

Dr. LEWIN. Yes, we are. I think the biggest concern we have right now, the biggest error we see happening in the planning for the future with the Health Security Act concept, is that the Nation feels that the Clintons are advised that they must subsidize small businesses and that out of that $167 billion, we are going to have some enormous amount of money subsidizing small businesses.

We have not seen that experience. We would like to see those subsidies go to bringing up the Medicaid and the gap insurance populations, giving States the resources they need to pay reasonable reimbursements and to really contribute well for those at-risk populations and underfunded and unincluded populations, because we think that will set up the level playing field that leads to the cost containment that comes out of competition in a socially and ethically conscious marketplace.

If we continue to underfund Medicaid and gaps for States, if we put subsidies, say, at small businesses that are not really needed if we create means tests, then frankly we are going to fail, because we are going to have lower funding for those disenfranchised popu-

lations, and they will not come in, and the whole system will not work. That is the cost-shifting problem.

Senator DURENBERGER. One other question. What do you think would happen in Hawaii right now if we redesigned the Medicare benefit so that it was at least as comprehensive as they are talking about for everybody else in the country, and we get away from this specific deal, but we give them a comprehensive benefit like I assume you are talking about being offered to other people, and what we do at this level is simply give a dollar amount to the company—Kaiser, Blue Cross, whoever it is—based on age, sex and health status in that community. Would most of the 65 and older and disabled buy into that kind of plan?

Dr. LEWIN. I think they would, because they perceive that they get a less effective health plan as soon as they shift over from their employer-based coverage to Medicare. I think they would be very happy to do that as long as they knew that the Federal Government was going to continue to fund it adequately.

Similarly, I think we could bring Medicaid up, save a lot of money and make the whole system more efficient by unifying the whole thing. We would like to see Medicare in this process, included fully.

Senator DURENBERGER. Apparently, the reluctance on the part of the administration to get into reform of Medicare is perhaps twofold. One is political—at least, that is what I have heard—and the other is that nobody over at HCFA apparently has figured out how you do this dollar amount based on age, sex, and health status. The third one, you have suggested, which is that maybe the elderly would not trust us to keep that level of reimbursement up.

Dr. LEWIN. That is the fear.

Senator DURENBERGER. But what I hear you saying is that on the basis of your experience, where you have everyone for the most part buying a health plan, the notion that at 65, they have to buy differently, and they have to put up with the same kinds of A, B, medigap and paperwork stuff that the elderly on the mainland put up with, that it would be an attractive way to go.

Dr. LEWIN. Yes. May I also just add that our Prepaid Health Care Act limits out-of-pocket costs to $1,500 per year for family coverage, and that is strict; and in fact, there is no deductible on the front of the program, so you get instant coverage. As soon as you come into the program, you are covered, first visit. There is no spend-down or anything.

The Medicare population starts out with a program that tends to cause them to have to spend money up front before they get covered for prevention, and then they find, basically, that their preventive services, their annual health assessments, all those things are deemphasized. And really, the poor elderly end up in the hospital in order to get covered.

Senator DURENBERGER. Thank you.

The CHAIRMAN. Under the administration's plan, of course, there are no copays at all for the preventive services.

You made a comment earlier that 90 percent of the doctors in Hawaii treat Medicaid and Medicare patients. What is the background on that? What is going through their minds?

Dr. LEWIN. Ninety percent of doctors in Hawaii are participants with the insurance companies for the work force in that there is no balance billing for 90 percent of the doctors; they accept what the insurers say are the levels of reimbursement. For the consumer, that means that they are not paying more out-of-pocket, so out-of-pocket costs are lower.

But also in Hawaii, physicians have been good about taking on Medicaid and Medicare clients. Recently, there has been a lot of concern that if there is any more reduction of Medicaid and Medicare reimbursements that more physicians may pull out. But 90 percent currently do.

The CHAIRMAN. Have you costed out what your administrative savings are from that?

Dr. LEWIN. It is very significant. The Hawaii Medical Services Association, which is the biggest Blue Cross/Blue Shield, the biggest of the private insurers, has an indirect cost rate that is 3 or 4 percent, or its administrative cost rate. And again, it is hard to imagine what it is like to be in an environment where you have a standard benefit package and standard economic conditions in terms of deductibles, copayments, etc, so everybody is competing on the same package. There are only a few insurance companies in the marketplace, and all that has caused a tremendous reduction of administrative costs. They are all using the same basic claim form now.

The CHAIRMAN. We thank you very much for your testimony, as well as the excellent testimony of Dr. Tyson. It has been enormously interesting. There are some areas of difference in terms of the employment figures, and I think there is, very interestingly, general agreement that even the cost for coverage of those who are not covered is not of great significance—whatever "great significance" is in terms of billions of dollars—but I think that in most people's minds, that is the major element in terms of additional cost, and I think the broad agreement we have on that is not insignificant.

We will be keeping in touch with you and drawing on all of you as we go through the weeks and months ahead. We are grateful to you all for your testimony here today.

The committee will stand in recess.

[Whereupon, at 1:01 p.m., the committee was adjourned.]

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